PUBLIC HEARING

JOINT LEGISLATIVE COMMITTEE ON AGING

Columbia, October 7, 1987

PUBLIC HEARING

BY

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

Columbia, SC - October 7, 1987

Representative Patrick B. Harris, Chairman

Representative Dave C. Waldrop, Vice-Chairman
Presiding

Joint Legislative Committee on Aging
212 Blatt Building
P.O. Box 11867
Columbia, SC 29211
Telephone - (803) 734-2995

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ADDITIONAL WRITTEN STATEMENTS SUBMITTED:

The Annual Public Hearing of the Joint Legislative Study Committee on Aging was held in the Blatt House Office Building, Room 101, in Columbia, South Carolina, on Wednesday, October 7, 1987.

OPENING REMARKS were given by Vice-Chairman Representative Dave C. Waldrop:

First of all I would like to introduce myself. I'm Dave Waldrop from Newberry, Vice-Chairman. I'm sitting in for Mr. Pat Harris who's under the weather. I'm sure most of you know he is in the hospital but he's doing very well this morning.

I would like to introduce the members present that serve on the Legislative Study Committee On Aging. Representative Dill Blackwell from Traveler's Rest has been a member since 1983. I think he and I probably came on about the same time or maybe he was a year ahead of me. Mrs. Gloria Sholin from Hilton Head is welcomed back as the Governor re-appointed her to this Committee. Mr. Tom Stilwell from Inman and Mr. Joseph Strickland from Columbia are newly appointed by the Governor to this Committee. Senator Lourie is expected to arrive at approximately 11:00. I would like to state that Senator Bill Doar from Georgetown and Senator Peden McLeod from Walterboro are not able to attend due to court conflicts.

One thing I would like to state at this particular time is that Randy Lee who is with the SC Health Care Association sends his regards. He can not attend since this is the opening day of his State Convention .

Also I'd like to recognize one representative with us. Rep. Kirsch from York is going to make a presentation later.

I would like to introduce the Committee staff, Keller Barron, Director; Sherri Craft, Research Assistant, and Donna Smith, Legislative Intern from USC - College of Social Work.

Also Mrs. Carolyn Schmitt at the back was kind enough to register everybody that came in this morning. Now hopefully I didn't miss anybody. All of you are important.

Now we would like to proceed with the Annual Hearing and we would like to limit each person to 10 minutes, unless persons from the Committee have particular questions.

Dr. C. M. Johnson, Chairman
S.C. Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223

REMARKS BY DR. C. M. JOHNSON, CHAIRMAN
SOUTH CAROLINA COMMISSION ON AGING
TO
LEGISLATIVE STUDY COMMITTEE ON AGING
PUBLIC HEARING, OCTOBER 7, 1987
COLUMBIA, S.C.

REPRESENTATIVE HARRIS AND MEMBERS OF THE COMMITTEE,

I AM C. M. JOHNSON, RECENTLY ELECTED CHAIRMAN OF THE COMMISSION ON AGING. I AM PLEASED TO HAVE THE OPPORTUNITY TO SPEAK WITH YOU THIS MORNING ABOUT OUR AGENCY AND THE ISSUES AND CONCERNS OF SOUTH CAROLINA'S OLDER CITIZENS.

FIRST, I WOULD LIKE TO EXPRESS MY PERSONAL APPRECIATION AND THAT OF OUR AGENCY FOR THE EFFORTS OF THIS COMMITTEE AND ITS MEMBERS. THE COMMITMENT YOU HAVE DEMONSTRATED HAS RESULTED IN IMPORTANT LEGISLATIVE ACTIONS THIS YEAR.

THANK YOU FOR INCLUDING IN-HOME COMMUNITY SERVICES AS A RECIPIENT OF A PORTION OF THE BINGO TAX REVENUE. ALTHOUGH AGING WILL RECEIVE ONLY A SMALL PERCENTAGE OF THE TOTAL REVENUE THAT 12% IS ESTIMATED TO PROVIDE BEGINNING JULY, 1988, AN ADDITIONAL $800,000 FOR IN-HOME COMMUNITY SERVICES IN THE COUNTIES.

THANK YOU FOR YOUR SUPPORT OF LEGISLATION TO RESCIND MANDATORY RETIREMENT FOR THOSE ACTIVE, ALERT CONTRIBUTING WORKERS WHO DO NOT WANT TO RETIRE. WE HOPE THIS BILL PASSES THIS YEAR.

THANK YOU FOR SUPPORTING 1/4 OF 1¢ OF THE GASOLINE TAX TO BE USED FOR PUBLIC TRANSPORTATION. WE HOPE IT WILL BE USED TO ASSIST THE ELDERLY IN MEETING THEIR TRANSPORTATION NEEDS.

YOU HAVE ALSO WORKED CLOSELY WITH NUMEROUS OTHER BILLS THAT HAVE A DIRECT IMPACT ON THE ELDERLY AND WE SINCERELY APPRECIATE YOU AND YOUR STAFF ALWAYS REMEMBERING TO CALL US AND ASKING OUR OPINION AND INVITING US TO PARTICIPATE IN THE DISCUSSION. WE ESPECIALLY COMMEND KELLAR BARRON AND HER STAFF FOR THEIR DEDICATION TO THE CAUSE OF THE ELDERLY.

THIS PAST YEAR HAS BEEN AN EXTREMELY TIGHT ONE FROM A FINANCIAL PERSPECTIVE. THE COMMISSION AND THE AGING NETWORK HAVE COOPERATED IN AN UNPRECEDENTED MANNER OF SUPPORT IN DIFFICULT TIMES.

THE GROWTH IN THE ELDERLY POPULATION IS PLACING INCREASING DEMANDS ON OUR STAFF WITH LITTLE OR NO RELIEF FROM A BUDGETARY STANDPOINT. THE SUBJECT OF MONEY IS ALWAYS A TOUCHY ONE ESPECIALLY IN TIMES OF ECONOMIC ENCERTAINTY. HOWEVER, THE COMMISSION'S BUDGET REQUEST IS VERY SMALL IN VIEW OF THE OVERALL STATE BUDGET. IN SOME INSTANCES YOU HAVE PASSED LEGISLATION MANDATING ACTION BY THE COMMISSION BUT NO FUNDS ARE ALLOCATED FOR THE TASKS. SEVERAL OF THESE AREAS ARE REFLECTED IN OUR BUDGET REQUEST THIS YEAR. OUR #1 BUDGET PRIORITY REMAINS AS IN-HOME COMMUNITY SERVICES WITH #2 BEING RESTORATION OF FUNDS TO AREA AGENCIES ON AGING. THESE FUNDS ARE USED TO PROVIDE THE STATE MATCH FOR FEDERAL FUNDS WHICH PROVIDE LOCAL SERVICES SUCH AS HOME DELIVERED MEALS, CONGREGATE MEALS, TRANSPORTATION, AND HOMEMAKER SERVICES.

WE URGENTLY NEED OPERATIONAL FUNDS FOR THE AGENCY WHICH HAVE NOT BEEN INCREASED IN SEVERAL YEARS.

WE NEED PLANNING TOOLS TO BE ABLE TO ESTIMATE THE NEEDS OF THE ELDERLY AND TO ASSIST YOU IN MAKING CHOICES ABOUT APPROPRIATE ALTERNATIVES IN THE ISSUE OF LONG TERM CARE.

WE MUST EDUCATE AND INFORM OUR CITIZENS AND WORKERS ABOUT THE PREVENTATIVE, WELLNESS CONCEPTS OF AGING AS WELL AS ABOUT THE PROBLEMS OF OLD AGE.

THIS IS THE YEAR TO PASS LEGISLATION THAT WILL CREATE A MARKET FOR LONG TERM CARE INSURANCE IN SOUTH CAROLINA AND TO ASSURE PROTECTION FOR THE CITIZENS WHO PURCHASE IT.

WITH THESE COMMENTS, I WOULD LIKE TO CLOSE. MRS. RUTH SEIGLER THE EXECUTIVE DIRECTOR OF THE COMMISSION WHO HAS NOW BEEN WITH US FOR ONE YEAR, WILL EXPAND ON THE DISCUSSION OF LONG TERM CARE FOR THE ELDERLY AND WILL GO INTO MORE DETAIL ON SOME OF THE TOPICS THAT I HAVE MENTIONED.

WE ALL HAVE A RESPONSIBILITY TO PLAN FOR OUR TOMORROWS. I AM GRATEFUL FOR A CARING AND CONCERNED COMMITTEE ON AGING WHO TAKES THEIR RESPONSIBILITY SERIOUSLY AND DILIGENTLY SEEKS SOLUTIONS TO THE PROBLEMS AND CONCERNS OF OUR SENIOR CITIZENS.

Ruth Seigler, Exec. Dir.
S.C. Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223

TESTIMONY BY RUTH O. SEIGLER
SOUTH CAROLINA COMMISSION ON AGING
TO
JOINT LEGISLATIVE STUDY COMMITTEE ON AGING
PUBLIC HEARING, OCTORER 7, 1987

REPRESENTATIVE WALDROP, MEMBERS OF THE JOINT LEGISLATIVE COMMITTEE ON AGING, THANK YOU FOR PROVIDING THIS FORUM TO HEAR ISSUES AND CONCERNS OF OLDER SOUTH CAROLINIANS. IT IS AN EXCITING DAY FOR THE S. C. COMMISSION ON AGING TO HAVE SO MANY PARTICIPATE IN STRONG ADVOCACY FOR THE ELDERLY. I AM ESPECIALLY PLEASED TO RECOGNIZE OUR FINE BOARD AND TO COMPLIMENT THEM PUBLICLY FOR THEIR COMMITMENT. . . I WOULD ALSO LIKE TO RECOGNIZE MRS. LEONA CUNNINGHAM WHO HAS BEEN NAMED THE OLDER SOUTH CAROLINIAN OF THE YEAR BY THE COMMISSION. MRS. CUNNINGHAM IS FROM LANCASTER, SOUTH CAROLINA. SHE RETIRED FROM BEING A PRINCIPAL AND SCHOOL TEACHER TO BECOME A VERY ACTIVE AND OUTSTANDING VOLUNTEER IN THE HOSPITAL, IN LITERACY TRAINING, AND IN OUR AGING PROGRAM. PLEASE JOIN ME IN APPLAUDING MRS. CUNNINGHAM.

IN MY REMAINING MOMENTS I WANT TO CALL YOUR ATTENTION TO THE PACKET OF MATERIAL WE PROVIDED AND HIGHLIGHT SEVERAL AREAS WITH YOU. FIRST, THE PAPER ENTITLED "AN ACTION PLAN FOR THE ELDERLY: A LOOK AT AGING AND LONG TERM CARE IN SOUTH CAROLINA." FINANCING LONG TERM CARE IS RAPIDLY EMERGING AS ONE OF THE MOST SERIOUS CHALLENGES FACING US. THE STARK REALITY IS THAT INDIVIDUALS AND FAMILIES PAY FOR LONG TERM CARE FROM SAVINGS AND AVAILABLE INCOME UNTIL THEIR RESOURCES ARE EXHAUSTED. AT THAT POINT THE STATE MEDICAID PROGRAM BEGINS PAYING THE BILL FOR NURSING HOME CARE AND SOME COMMUNITY BASED SERVICES. THE CURRENT SYSTEM IS FRAGMENTED, LIMITED, AND INADEQUATE. THE QUESTION BEING ASKED BY IMPROVISHED SPOUSES, BY INDIVIDUALS FACING THE INDIGNITY OF LOSING THEIR LIFETIME SAVINGS, BY FAMILIES SACRIFICING TO CARE FOR THEIR OLDER MEMBERS AND THE STATE IS . . . "HOW WILL WE PAY?" LET'S LOOK AT THE DIMENSIONS OF THE PROBLEM. SOUTH CAROLINA'S POPULATION IS GROWING OLDER. IN FACT IN 1985 THE STATE EXPERIENCED A 19% GROWTH IN ITS ELDERLY POPULATION. ELDERLY FEMALES

OUTNUMBER ELDERLY MALES IN INCREASING PROPORTIONS. BY 2000, SOME 63% OF THE ELDERLY POPULATION WILL BE FEMALE. WHILE THERE HAVE BEEN SOME INCREASES IN LONGEVITY FOR THE BLACK POPULATION, THE RATIO OF WHITE ELDERLY TO BLACK ELDERLY IS 3 TO 1.

THERE ARE SEVERAL OTHER IMPORTANT DEMOGRAPHIC FACTORS THAT IMPACT PUBLIC POLICY IN SOUTH CAROLINA. WE HAVE A VERY HIGH ILLITERACY RATE AMONG OUR ELDERS--25 PERCENT--AND A HIGH POVERTY RATE--25 PERCENT. IF YOU COMPARE THESE PERCENTAGES TO NATIONAL RATES IT BECOMES VERY CLEAR THAT WE HAVE SOME SPECIAL PROBLEMS TO DEAL WITH . . .

WE ARE ALSO EXPERIENCING RAPID GROWTH IN OUR VERY OLD POPULATION--THOSE OVER 75.

PLEASE LOOK AT CHART D ON PAGE 24 . . . AT THE PREVALENCE OF CHRONIC CONDITIONS #1 - ARTHRITIS, #3 - HEARING IMPAIRMENTS, #6 - VISUAL IMPAIRMENTS. IMAGINE A WIDOWED FEMALE EIGHTY FIVE YEARS OF AGE WITH ARTHRITIS WITH LIMITATIONS OF HEARING AND EYESIGHT WITH LESS THAN AN 8TH GRADE EDUCATION AND AN INCOME OF $4,800--LIVING IN RURAL SOUTH CAROLINA AND RECENTLY DIAGNOSED WITH DIABETES. THE SCENARIO REPORTS ITSELF ALL OVER SOUTH CAROLINA EVERY DAY AND REPRESENTS THE DILEMMA FACING OUR AGING, THE AGING NETWORK, AND YOU AS PUBLIC POLICY MAKERS. WE KNOW THAT MOST INDIVIDUALS ENTER LONG TERM CARE INSTITUTIONS WHEN THEY BEGIN TO EXPERIENCE MULTIPLE PROBLEMS WITH ACTIVITIES OF DAILY LIVING. PLEASE REFER TO PAGE 11.

SOUTH CAROLINA IS CURRENTLY SPENDING $100+ MILLION IN FEDERAL AND STATE DOLLARS FOR NURSING HOME CARE TO CARE FOR APPROXIMATELY 3% OF THE ELDERLY POPULATION. WHAT OTHER OPTIONS SHOULD WE BEGIN TO ESTABLISH TO ACCOMMODATE THE ANTICIPATED GROWTH. PLEASE REFER TO PAGE 15 OF THE ACTION PLAN.

I. EXPAND PRIVATE LONG TERM CARE

A. ADOPT THE MODEL ACT FOR LONG TERM CARE INSURANCE.

B. ENCOURAGE EMPLOYERS TO OFFER LONG TERM CARE INSURANCE TO EMPLOYEES.

C. REQUIRE THE STATE TO OFFER STATE EMPLOYEES THE OPTION OF PURCHASING GROUP LONG TERM CARE INSURANCE.

II. AUTHORIZE THE STATE HOUSING AUTHORITY TO DEVELOP A HOME EQUITY CONVERSION PROGRAM FOR THE ELDERLY AND ENCOURAGE BANKS AND MORTGAGE LENDING INSTITUTIONS TO OFFER SIMILAR PRODUCTS.

III. ENCOURAGE THE DEVELOPMENT OF CREATIVE HOUSING ALTERNATIVES SUCH AS SHARED HOUSING, FOSTER CARE FOR THE ELDERLY, FAMILY INCENTIVES, ETC.

IV. WORK CLOSELY WITH THE LONG TERM CARE COUNCIL GIVING PRIORITY ATTENTION TO ITS LEGISLATIVE MANDATE TO RECOMMEND A STATEWIDE SERVICE DELIVERY SYSTEM.

V. ENCOURAGE INNOVATION FINANCING AND DELIVERY MODELS.

VI. EXPAND HOME AND COMMUNITY BASED CARE - I WOULD LIKE TO CALL YOUR ATTENTION TO THE #1 PRIORITY--BUDGET REQUEST OF THE COMMISSION FOR $2.1 MILLION TO CONTINUE THIS INITIATIVE.

VII. EXPAND CONSUMER EDUCATION - PLEASE REFER TO PRIORITY 6 AND 9 OF THE COMMISSION'S BUDGET REQUEST.

VIII. IMPROVE DATA AND LONG TERM CARE PLANNING AND FINANCING.

1. FUND THE S. C. PANEL STUDY OF THE ELDERLY — THIS IS PRIORITY #5 IN OUR BUDGET REQUEST.

2. SUPPORT THE DEVELOPMENT OF THE S. C. DEMENTIA REGISTRY.

FINALLY, I HOPE YOU WILL FEEL FREE TO USE THIS ISSUES PAPER TO HEIGHTEN AWARENESS OF THE PUBLIC AND YOUR COLLEAGUES IN THE HOUSE AND THE SENATE. YOU ARE OUR STRONG ALLIES AND ADVOCATES. WE APPRECIATE YOUR CONCERN AND DEDICATION TO OUR CAUSE. PLEASE FEEL FREE TO CALL ON US TO ASSIST YOU WITH THE PROBLEMS YOUR CONSTITUENTS FACE. I AM VERY PROUD TO SAY WE HAVE A CONCERNED AND COMMITTED AGING NETWORK AND IT IS OUR JOB TO WORK WITH YOU TO TRY TO FIND SOLUTIONS FOR THESE PROBLEMS. INVESTMENT IN THE ELDERLY IS NOT ONLY WISE PUBLIC POLICY, IT IS ESSENTIAL PUBLIC POLICY.

Rep. Blackwell - Mrs. Seigler, thank you for your testimony and your suggestions. Is it your position that we take legislative action in order for programs such as Home Equity Conversion or reverse mortgages to be allowed in this state?

Seigler - Rep. Blackwell, we have met with the State Housing Authority to discuss this and they have placed it as a priority before their board. It is my understanding that they have approved it. I am not familiar enough myself to be able to answer the question about whether legislation is required. It would require a bond, as I understand it, so they would be able to issue Home Equity Conversion models to the elderly at a reduced percentage rate. But as to whether they have the authority in their current legislation, I'm not cetain about that.

Rep. Blackwell - Could you suggest a state where this is working satisfactorly?

Seigler - Yes sir, Connecticut and Virginia both have this model in place.

Rep. Blackwell - Mr. Chairman, I'd ask staff please to get us some copies of this legislation. So that we will have it when we are considering what legislation we are going to consider. Thank you so much.

Advisory Council on Elder Affair
P.O. Box 343
Charleston, SC 29402

SOUTH CAROLINA COMMISSION ON AGING

ADVISORY COUNCIL ON ELDER AFFAIRS

POSITION PAPER

THE NEED FOR LONG TERM CARE INSURANCE

BACKGROUND

There is a great need to expand long term care services for older persons. At the same time there is a need to encourage more ways to finance these services. The growth of comprehensive long term care insurance, with adequate consumer safeguards, can help provide the means to pay for long term care services. Private insurance can help protect older persons and their families from financial ruin due to the medical and maintenance costs of a long term illness.

The Department of Health and Human Services predicts by the year 2000 one in four Americans who reach retirement at age 65 will eventually enter a nursing home. Nursing home population, now 1.2 million nationally, is expected to double in the next 14 years.

In South Carolina the over 65 population is growing twice as fast as in the nation as a whole. The rate of growth between 1980 and 1990 is expected to reach 45 percent. The 60 and over population, some 500,000 persons, is nearly 15 percent of the state's total population. The poverty level among older persons is higher, some 23 percent of the population in the state, than the 16 percent for the nation. This high rate increases the potential impact on the state's Medicaid funds.

Nationally, about one third of nursing home residents begin their stay by providing their own financing but within six months these persons have exhausted their funds and qualify for Medicaid. If adequate long term care insurance were available many of these individuals would not need government support.

The development of adequate private long term care insurance has been hindered by: (1) the public's erroneous view that Medicare or Medicaid or private Medigap policies would provide adequate protection against long term care costs; (2) uncertain regulatory climate in the states, including South Carolina; (3) lack of adequate data on which to base the pricing of insurance; and (4) current regulations that encourage people to "spend down" their assets in order to qualify for long term care services under Medicaid.

In 1986, 14 states passed legislation regulating long term care insurance. This legislation either established studies of long term care insurance or set up standards for such policies. The National Association of Insurance Commissioners has developed a Long Term Care Insurance Model Act for use by states interested in encouraging the further development and availability of long term care insurance. The Act seeks to protect applicants, establish standards for policies, facilitate public understanding and comparison of policies and promote flexibility and innovation in the development of coverages.

In South Carolina, NAIC Model Act has been introduced in the House as H.2673 and in the Senate as S.603. No action was taken in the 1987 legislative session. This legislation appears to be relatively non-controversial at this time. Favorable reaction appears to exist among the insurance industry, state American Association of Retired Persons, the Insurance Department and some organizations representing the aging.

CONCLUSION

Long term care insurance, if sufficiently encouraged and fairly marketed to consumers, can help protect against the costs of long term illness, preserve individuals' assets and reduce the need for government support.

RECOMMENDATION

That the South Carolina Commission on Aging support the enactment of H.2673 and S.603, with amendments which would adequately protect consumers.

Dr. Sue Scally
Central Midlands Regional
Planning Council
800 Dutch Square Plaza
Columbia, SC 29203

TESTIMONY
PRESENTED TO
THE STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
BY
SUE L. SCALLY
VICE CHAIRPERSON
S.C. COMMISSION ON AGING
ADVISORY COMMITTEE ON ALZHEIMER'S DISEASE AND
RELATED DISORDERS INITIATIVES

This is the third year I have appeared before you on behalf of the Commission on Aging's Advisory Committee on Alzheimer's Disease Initiatives. In looking back on the issues we presented that first year (1985), I am pleased to report that much progress has been made in our state's response to the needs of families with Alzheimer's Disease and other types of dementia. Many of those accomplishments have resulted from the intense efforts and solid commitment of the members of your committee. We thank you.

Please allow me to review briefly some of the areas where more planning and more resources are still desperately needed:

1.) As noted by Mrs. Seigler in her testimony, private sector long term care insurance is an important health care financing option whose development must be both encouraged and regulated. It offers financial incentives both to the state through prevention or delay of Medicaid conversion by private pay long term care clients and to the family through prevention of spousal impoverishment and exhaustion of family resources. Long term care insurance thus is a financially attractive tool that allows the family to participate in the continued cost of care for their family member. At the same time, our Committee would continue to caution that illnesses such as Alzheimer's not be categorically excluded from such coverage, that policies provide for intermediate care, and that the covered time in nursing facilities be as long as possible. These provisions are critical if long term care insurance policies are to be beneficial to dementia families.

2.) Our Committee has consistently appealed for more funding for in-home services such as respite and homemaker and for more adult day care programs. These are services most often requested by dementia families and experience is now showing that they will use these services when available. The $250,000 appropriated to the Commission on Aging has helped to start or enhance existing services and the bingo tax revenue will increase these efforts. But, let us be clear, we as a state are just beginning to play "catch up"; these dollars will still be far from adequate to address the mushrooming need for long term care. We urge your support for the Commission's request for an additional $2.1 million.

3.) We spoke to you two years ago about the lack of available data to support sound planning for dementia care services. The proposal developed by the USC School of Public Health to establish a dementia care registry is commendable and would go far in filling the data void that currently exists. We endorse their effort and hope that the appropriate state agencies will provide needed resources to make it a reality.

4.) As we have noted in the past, most victims of Alzheimer's Disease and related disorders will spend the later stage of the illness in a nursing care facility. Despite plans by many private nursing homes to develop special dementia programs or units within their facilities, we have not yet come to grips with the issue of standards for these programs; nor do we have standards for those public facilities primarily treating dementia patients. We would ask this Committee to consider legislation to require the Commission on Aging, the State Nursing Home Ombudsman, DHEC, DMH, and the State Health and Human Services Finance Commission to develop such standards. Our Advisory Committee and representatives of family support groups around the state stand ready to assist in that effort.

5.) Finally, we share in the Commission's excitement about the Alzheimer's training demonstration grant they have been awarded from the Administration on Aging. The training they plan for health care and social service providers will result in a vast improvement in understanding of the illness and the quality of care provided to its victims -- both those who have the illness and those who care for them.

Again, we wish to take this opportunity to thank the Commission for the leadership it is providing and to thank you for your support and commitment to a growing number of older persons who cannot speak or act on their own behalf.

SLS/ha
10/07/87

Lower Savannah Council of Govts
P.O. Box 850, Highway 302
Aiken, SC 29801

PUBLIC HEARING TESTIMONY

JOINT LEGISLATIVE COMMITTEE ON AGI

OCTOBER 7, 1987

S. C. ASSOCIATION of AREA AGENCIES ON AGING

Today, the South Carolina Area Agencies on Aging , along with the entire Aging Network, wish to express our appreciation to you for your many significant accomplishments during the last legislative session.

As you know the overall goal of the Area Agency on Aging is to develop, coordinate and promote a comprehensive, areawide aging network system that will enable the older people of this state to lead independent lives in their own homes in dignity for as long as possible. In developing this community based service delivery system, the Area Agency undertakes annual planning activities to obtain updated information on the status and needs of the older citizens; inventory the resources and services available from public and private sources to meet the identified needs and evaluate their effectiveness; develop and administer a comprehensive multi-year area plan for their region; sub-contract program funds obtained by the Area Agency to local providers for the delivery of services; secure additional resources to assist local providers in developing new, innovative programs to benefit the older citizens of the region; provide technical assistance to local governmental jurisdictions and other aging service providers; and, serves as an advocate to enhance awareness by service providers, community leaders, civic groups, the corporate and voluntary sectors, and elected officials regarding the identified needs of the older citizens.

It is in this advocacy role that we appear before you today. Given our responsibility to develop a community based, comprehensive system and the identified gap in this system, we especially wish to commend your efforts in securing designation of a percentage of the Bingo Tax Bill revenue for

in-home services for the frail, elderly citizens of our state. We realize and appreciate the many hours of hard work that were required in order to successfully negotiate legislation establishing a [redacted] financial base r these in-home support services. And you need to be aware that the entire Aging Network, including the Area Agencies, was behind you 100%, and will continue to be as we endeavor to secure an adequate, permanent financial base for these services for the older citizens of this state.

The testimony just presented by Mrs. Seigler, the Executive Director of the South Carolina Commission on Aging, graphically illustrates that we have not realized this posture. It demonstrates that, despite our successful efforts of the last session, we cannot afford to rest on last years' accomplishments given the acuteness of the need. Yet there are some in this state who would question the need for and use of these funds. That is a valid concern given current budgetary constraints. Accordingly, let us take this opportunity to provide a couple of examples of how these funds have been used and what impact they had since the initial $250,000 appropriation for these services in 1985-86.

In the Central Midlands region, the Area Agency used this initial appropriation to establish a respite care program in each of the four counties. One example of an in-home respite care client follows:

> Mr. "L" is a 77 year old man who lives with his son and his family, and relies on his daughter-in-law for personal care. His daughter-in-law has 2 young children to care for and receives very little help from family in caring for her father-in-law. At the time that in-home respite care services were initiated, Mr. "L" was bedridden for the most part relying on his daughter-in-law to get him into his wheelchair every day. This was due in part to a stroke which left him with left-sided weakness, and in part to the amputation of his leg i year prior. From October 1986-July 1987, the Newberry County Council on Aging has given them 148 hours of respite care, which consisted of personal care, exercise, companionship, motivation encouragement and emotional support. Maybe in part because of this, Mr. "L" is now able to move himself from his bed to his wheelchair without help, shave himself, and is now able to speak more clearly.

In the Santee-Lynches region, the Area Agency used the initial appro-

priation to assist in the implementation of an Adult Day Care/Respite Care program at the Kershaw County Council on Aging. This program was initiated seven months earlier when the community recognized the need for the service and local resources were provided to begin the program. An example of the client served is :

> Mr. "M" is 66 years old and lives with his wife, Mrs. "M", who is 64. They have three children all of whom have a full-time job. At the time of referral, Mr. "M" was believed to be in the initial stages of Alzheimers. He was exhibiting erratic behavior, wandering and incontinent. Mrs. "M" was providing 24 hour care for her spouse. According to her doctor, this was exacerbating her high blood pressure problems, bringing her to the point of complete exhaustion and contributing to increasing incoherence. Further compounding the problem was an unstable family situation in which all three children were bringing increasing pressure to bear on their mother to institutionalize her husband and providing no support. This was critical in that neither Mr. or Mrs. "M" could drive. Mr. "M" now participates in the Adult Day Care program 3 days a week. It has taken time for him to adjust, but through the efforts of a trained volunteer working with him on a one-to-one basis, he no longers wanders as much nor cries when his wife leaves. The Council on Aging provides him with transportation to the program and also provides transportation for his wife those three days so that she may do essential shopping, keep doctor appointments, etc. According to her doctor, this respite has allowed Mrs. "M" to regain control of her life, begin to think more clearly, communicate her needs and concerns directly with their children, and, consequently, family problems have stabilized.

As you can see, these funds haye had a significant impact which will only be furthered by the designated revenue from the Bingo tax. However, the harsh reality is that we have only just scratched the surface in meeting this need. All across our state waiting lists for these services already exist and they continue to grow daily. With the accelerated rate of the growth of our elderly and the in migration of retirees to our state, this unacceptable situation can only escalate. We strongly endorse the $2.1 million dollar request contained in the S. C. Commission on Aging Budget Request. That funding, combined with the continuing state appropriation for community services and the bingo tax revenue, will allow for sufficient funds to continue the support and growth of innovative programs that will enable our older citizens, and their family caregivers, to lead independent lives in thier own homes with dignity for as long as possible.

While it is our bias that in-home services are to be preferred where an alternative exists, the level of care offered by our nursing homes in intermediate and skilled care facilities is a valuable community resource. It is a resource that, when the situation is appropriate, should be utilized. The State of South Carolina faces the prospect of rapid increases in the cost of its Medicaid program as our population ages. A growth rate of 45 percent is projected for the period 1980-1990 of the over 65 population. The high rate of older persons in our state living in poverty, 23 percent compared to 16 percent nationally, increases the potential impact on the state's Medicaid funds. Consequently, it would be advantageous for the State to actively pursue the development of alternatives for privately financed long-term care services, including coverage of in-home support services as well as nursing home/institutional care. One such alternative is private long term care insurance. The continued development and expansion of private long term care insurance in our State can help reduce the number of individuals who "spend down" their income and assets to qualify for Medicaid. Nationally, roughly one-third of nursing residents originally entered as private pay patients before conversion to Medicaid, which suggests that many had the necessary resources to purchase private long term care insurance were it available and included appropriate consumer safeguards. In the last legislative session, the National Association of Insurance Commissioners Model Act was introduced (H.2673 and S.603), with no action taken. It appears to be relatively non-controversial and supported by the Insurance Department, the insurance industry, AARP, and other organizations representing older citizens. Therefore we support and encourage your support for the enactment of H.2673 and S.603, with appropriate amendments to sufficiently protect consumers.

Currently in South Carolina even if an adult falls into one of the populations permitted Medicaid coverage, the spouse (where married) must also become

impoverished to meet income criteria. All jointly held resources and property are considered by the State as patient assets in determining eligibility. Both spouses must meet the income guidelines, even if only one spouse is applying for Medicaid assistance. This results in two persons living at the poverty level. We encourage your development and introduction of legislation to protect families from impoverishment so that victims would qualify for medical assistance without impoverishing the entire family.

In October, 1986, Congress outlawed mandatory retirement on the basis of age alone through the passage of amendments to the Age Discrimination in Employment Act. The Joint Legislative Committee, in conjunction with the State Retirement System and the Human Affairs Commission, introduced legislation to repeal the mandatory retirement provision of S. C. law, S.379, during the last session. S.379 passed the Senate, received third reading in the House, was reconsidered and referred back to the House Ways and Means Committee. We request your support in securing enactment of this legislation during the 1988 Legislative session.

The USC School of Public Health has submitted a proposal for a grant to establish a Dementia Registry for South Carolina. This was more fully addressed during earlier testimony at this hearing. We wish here to go on record in support of the establishment of this Dementia Registry for South Carolina.

As Winston Churchill stated, "A civilization will be judged by how it treats its elderly." The challenge is before us. We pledge to join with you in our continuing partnership to successfully meet the challenge.

Rep. Waldrop - Any questions for Ms. Shade? At this time I'm going to interrupt the agenda just briefly. Mr. Kirsch, we will get to you very shortly but I'd like to drop down to Ms. Kay Jamerson-McDonagh, President of the SC Association of Council on Aging Directors. I think she has something special she's like to do for Senator Lourie for people who didn't see him sneak in the back door.

PRESENTATION OF AWARD

TO SENATOR ISADORE LOURIE

FROM THE S.C. ASSOCIATION OF COUNCIL ON AGING DIRECTORS

Presented by Kay Jamerson-McDonagh, President

Senator Isadore Lourie's work and efforts in our behalf compel us to acknowledge in some way our sincerest appreciation to him. We are honored that he has chosen to lend the enormous prestige of his name and reputation to our interest. We requested this morning the opportunity to repeat this recognition in a more public forum. The award reads - "presented to Senator Isadore E. Lourie by the SC Association of Council on Aging Directors in grateful recognition of writing dedication and committment to enhancing the lives of Senior Citizens through legislative leadership." As stated at the initial presentation, Senator Lourie most certainly has already and will in the future receive far more prestigious awards but none will ever be given or presented with more sincerity or deeper affection.

Senator Lourie - I apologize for being late Mr. Chairman. I have to speak to the Council on Aging down in Eastover which is at the heart of my senatorial district at about one o'clock. So I will have to leave a little earlier, but I wanted to thank the Directors again for the award and it means a great deal to me. I've been honored before but I don't think I have ever felt or received an award that meant more to me than this. All of us together shared many endeavors. Twenty-five years I've been part of the legislature. I suppose I'm as proud of legislation establishing the Commission on Aging, Homestead Exemption, Sales Tax on Drugs, now the Bingo Revenue allocation for Home Care for the Elderly and many other programs we all undertook together. Certainly efforts of this Committee and former Governor Riley, Travis Medlock, and Nick Theodore have been very helpful in all of these endeavors. I'm just very proud of this award and it is one that I will hang with great honor. Thank you very much.

Rep. Waldrop - Senator I'd like to add a couple of things to your remarks from Members of the Committee, especially ones that have served with you. We know what you can do and to those persons out there who do not know Senator Lourie, for twenty-five years he's been a truly dedicated person to the Aging Network and always will be, in my opinion, one of the greatest senators over there. He has a way of doing things just like sneaking in the side door. He has a way of getting in and getting out but he always gets it done and that's the main thing. I'm proud of him and I appreciate the fact that this award could be given to him at this hearing. Thanks.

Representative Herbert Kirsh
P.O. Box 31
Clover, SC 29710

PRESENTATION BEFORE THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING
BY HERBERT KIRSH

OCTOBER 7, 1987

In June of this year, Catawba Regional Planning Council made the decision to no longer be the Area Agency on Aging (AAA) for the Catawba Region which consists of Chester, Union, Lancaster and York counties. The withdrawal of of Catawba Regional Planning Council has given the local agencies and communities the opportunity to evaluate the AAA level of administration at a time when funds are so limited.

The cost to administer the AAA for the Catawba Region is approximately $111,000($26,000 of this is local match) It has long been the feeling of the local boards that the majority of duties of an Area Agency on Aging have been done at the county level and merely compiled at the regional level. Therefore, the Catawba Region Aging programs have the expertise to continue to handle the responsibilities of planning, resource development, advocacy, coordination, community education and program development on their own.

The Catawba county aging programs are currently operating directly under the South Carolina Commission on Aging while the commission is seeking to establish another AAA in this Region. I have requested of Mrs. Ruth Seigler, Executive Director of the SCCOA, that she consider the recommendation of each county in the Catawba Region being designated as a Planning and Service Area (PSA) and be permitted to be their own AAA. Mrs. Seigler's response indicated that this formation does not provide for effective regional planning and coordination. I fully understand this need to comply with the intent of the Older Americans Act, but feel that $111,000 is a lot of money for pure administration without any direct services.

The four counties of the Catawba Region have developed what I feel to be, a very workable solution to the problem of regional planning and coordination. They propose the establishment of a consortium whose purpose would be the regional planning, monitoring, needs assessment and coordination of training. This consortium will be composed of representatives of social agencies dealing with the elderly, county planners, health care and educational professionals and the county council on aging directorss. This group of aging professionals would be far better equipped to assess the needs of the region and plan for implementation of services than any single person not directly associated with the provision of services to the elderly. This consortium would provide for a closer alignment of agencies and groups toward the common goal of quality services to the elderly of the Catawba Region. It would also ensure the meeting of true, rather than perceived,needs. The establishment of this consortium would provide the best of both systems-the concept of regional planning and the cost effectiveness of single county administration.

I realize that the administrative cost at the South Carolina Commission may increase somewhat, but not to the financial extent of the formation of a completely new agency with all the inherent costs of overhead and the cost of two and one-half staff persons as required for an AAA.

It is my hope that the South Carolina Commission on Aging would be willing to consider a totally new concept as a pilot project for at least a reasonable period of time and then assess the quality, responsiveness and workability of this plan. The consortium members have already demonstrated a committment to the elderly of our state and region, while a professional administration may not have that committment as well as the ability to administer the programs.

It is not more administration that we need, but more committment to the elderly and direct service dollars. We want to let out region lead the way to a new beginning in aging administration.

Rep. Blackwell - Herb, I of course share your feeling about saving administrative cost. About what percentage of the state's population of elderly persons fall in that fourth county area.

Rep. Kirsh - Honestly, I can't answer that. I think there's one other group in the state from the Lower Savannah or Upper Savannah. I don't know what percentage of population it is.

Rep. Blackwell - Would the Reorganization Commission get involved in this at all or would this just be done as a demonstration?

Rep. Kirsh - No, I think this is strictly a COA decision.

Rep. Blackwell - Do you have any indication whether the COA is willing to consider it?

Rep. Kirsh - Well we've written several letters to Mrs. Seigler . I think that they've put out applications for the Winthrop College based Catawba Regional Planning Council and several others. As far as I know, no one has taken them up on it yet. I don't know the answer to that because I haven't talked to her in the last few days, but I haven't heard of any of any agencies coming forth.

We have experienced folks involved. I feel like they can save the administrative cost with direct services.

Rep. Blackwell - Thank you sir.

Rep. Waldrop - Rep. Kirsh, what will happen to this money?

Rep. Kirsh - The money is going to go there anyway I believe, Rep. Waldrop.

Rep. Waldrop - It's going to be there. Right?

Rep. Kirsh - It's going to be there. The question is where to spend it.

Rep. Waldrop - Whether administration route or another route.

Rep. Kirsh - We have seen this in other agencies. But when you have to cut, you would rather cut administration if you possibly can and keep funding in direct services.

David Caughman
Pee Dee Regional Council
of Governments - AAA
P.O. Box 5719
Florence SC 29502

PUBLIC HEARING TESTIMONY

JOINT LEGISLATIVE COMMITTEE ON AGING

OCTOBER 7, 1987

PEE DEE REGIONAL AREA AGENCY ON AGING

Good morning Mr. Chairman and members of the Joint Legislative Committee on Aging. Thank you very much for this opportunity to speak before you as an advocate for the elderly and as Chairman of the Pee Dee Regional Council of Governments Area Agency on Aging Regional Advisory Committee.

Years ago Mark Twain remarked all good things come to those that wait and don't die in the meantime. That axiom has pretty much characterized public policy and the rehabilitation of the elderly until now.

On August 27, 1987, the SCCOA prepared and presented An Action Plan for the Elderly in S.C. to Governor Campbell and the Budget and Control Board.

The Area Agency on Aging profoundly supports and places a high premium on the positive affect offered by the implementation of such a dynamic action plan.

As outlined in the Action Plan, health care assistance is a special concern of the elderly statewide.

Estimates of the proportions of people age 65 and over needing some kind of long-term care range from about 11 percent to about 20 percent. Estimates for the proportion of people 85 and over needing some kind of long-term care services range from about 35 percent to 62 percent. We estimate that there are at least as

many people who need and cannot afford long-term care services and are not eligible for Community Long-Term Care as there are being served by CLTC. Some of these people may be able to contribute some portion of the cost of services, but many cannot.

The needs far exceed the current resources despite our constant efforts to coordinate and cooperate. Many older people fall through the cracks. They have the degree of sickness to qualify for CLTC, but they are not Medicaid eligible. Others are poor enough to qualify for Medicaid but are found, in the screening process, to be too well to qualify.

For those reasons and many others not mentioned, the Pee Dee Area Agency on Aging supports the request by SCCOA for funding Alternative Care for the Elderly "ACE" ---$ 2.1 million dollars. A program designed as an alternative to institutionalization and is an alternative to CLTC for those who are ineligible for that program.

The Aging Network is a proven and existing network that covers the entire country. We are the logical entity to assume some of these proposed responsibilities. Our purpose is to assist older persons to remain in their communities and homes, which is the original intent of the Older Americans Act.

It is my belief that we should not listen to discussions about reductions in services for needy older persons. Rather, we should be planning for responsible ways to supply even more needed services to this dramatically expanding population. We cannot allow incomprehensible changes in public policy to erode

a very limited support system for needy older persons. We need the continued support of your committee to meet these critical challenges.

Although age is sometimes called the great equalizer, today's elderly are a highly diverse group. Differences in income, health, and social supports significantly affect the elderly's qualify of life.

My second plea -- In S.C., the Model Act has been introduced into the House as H.2673 and in the Senate as S.603. No action was taken in the 1987 Legislative Session. Long-Term Care Insurance, if sufficiently encouraged and fairly marketed to consumers, can help protect the cost of long-term illness, preserve individual assets, and reduce the need for government support.

We want to maintain a strong network at the local, regional, and state levels. We want to strengthen the role of the Area Agency on Aging. We continuously want to emphasize the importance of the advocacy role of the Area Agency.

Aging planners have clearly determined that older citizens and their families prefer to avoid institutionalization. The home environment usually affords the older person a greater sense of independence, dignity, and well-being.

The $2.1 million dollars would allow for sufficient funds to continue the support and growth of innovative programs to assist family caregivers and expand in-home services such as: homemaker/ personal care services, additional home-delivered meals, respite for the caregivers, and adult day care.

$2.1 million dollars and support of long-term care insurance is our cry.

In conclusion, I have outlined some critical issues and concerns that not only affect the outcome of the Pee Dee Region but also the State of S.C. The Area Agency on Aging Advisory Council and COA want to continue to demonstrate our ability to be a responsive and strong component within the aging network. We look to your committee to continue to support the successes of our network.

Thank you!

Rep. Blackwell - Mr. Caughman, this bill, LTC insurance is tied up in Insurance Law sub-committee Labor, Commerce, and Industry Committee. Have you folks appeared before that sub-committee? Has it even been considered by the sub-committee to your knowledge, sir?

Caughman - Sir, I have no knowledge of that.

Rep. Blackwell - I might suggest to those of you who are advocating that the Chairman of the Labor, Commerce and Industry Committee is Mr. Dangerfield of Charleston and Chairman of the Insurance Law sub-committee is Mr. John Bradley of Charleston. So perhaps you need to get your Charleston folks involved in this thing in a big way. The bill is going to have to be considered by the committee/sub-committee and reported out of Labor, Commerce and Industry before we can do anything to help you. Of course, we make our wishes known to those committees but if we could have positive efforts on your part in Labor, Commerce, and Industry Committees, it might be a big help, especially if you have some Charleston influence.

Michelle Hudson, AAA Unit Dir.
Waccamaw Regional Planning
Council
P.O. 419
Georgetown, SC 29440

Good morning.

I stand before you today on behalf of a group of people who would like to be here to testify, but cannot. Who? The frail elderly of the Waccamaw region. Out of the approximate 28,000 seniors of that area, there may be as many as 5,000 who are "at risk" for institutionalization.

Today, I'll discuss two issues. The first, is the need for legislation for coverage of prescription drug costs for non-Medicaid clients. The second is long-term care insurance. Many points are already being stressed.

Yes, we're getting older. Whereas the television heroes of yesterday were "Leave it to Beaver", today it is the "Golden Girls". But we must take these matters seriously.

And, along with this, we must recognize that certain issues are very important. For example, older adults comprise 11% of the population but spend 30% of all costs for prescription drugs. Many do without food and other necessities in order to buy medicine.

What are other states doing to alleviate this situation? For example, older New Yorkers can now save on their prescription drug costs by enrolling in the state's new Elderly Pharmaceutical Insurance Coverage Program, which can cover up to 50% of prescription drug costs. An applicant has to be over 65 years of age. Assets are not counted and older persons are not eligible if they are covered by Medicaid. Both brand-name and generic drugs are covered.

Eight other states are offering assistance in purchasing drugs for seniors. They are Connecticut, Delaware, Illinois, Maine, Maryland, New Jersey and Pennsylvannia.

One may ask, "Why the need for long-term care?" Let's take a case example. Miss S., never-married, is 85 and lives in a nursing home. She is not seriously ill, but poor eyesight and a bad back make it hard for her to take care of herself. She could have stayed in her apartment if adequate subsidized home care were available. Mrs. T, a widower is luckier. She's 86 and frail but still able to live alone. Not much longer, though. It's too hard for her to clean the house and frightening for here to go out. Mr. F. is 85 and a widower. He is luckiest. He's disabled, but his daughter has agreed to take care of him, though it means giving up her job.

The 1982 National Long-Term Care survey reported that 18% of the over-65 population needed the help of others in activities of daily living. A Massachussets study found that about half of a sample of elders would "spend down" to Medicaid's impoverishment levels after only 13 weeks of nursing home care.

It is critical to recognize that, in a period of increasing federal deficits, the federal government will not likely be the sole funding source for long-term care. Individuals and families cannot reasonably be expected to pick up the growing expenditures for long-term care without assistance.

As Mrs. Seigler has indicated, the state of Connecticut has developed a Task Force to study public and private responsibilities for financing long-term care for the elderly. Specific recommendations, which may be applied to South Carolina, include:

1) The state should encourage emploters to offer long-term care insurance to employers and appropriate dependents either through employer-funded plans or on an employee-paid basis.
2) The state should encourage the private sector, including insurance companies, HMO's and continuing care communities to develop and offer various risk-pooling products for the private financing of long-term care.
3) The state should offer to its employees the option of purchasing group long-term care insurance.

One study by the American Association of Retired Persons showed that 80% of constituents thought that Medicare paid for more than what it actually does. This indicates that there is a wide gap in the system of the dissemination of relevant information to older consumers. Therefore, the state should aggressively pursue demonstrations of new long-term care service delivery and financing models on an experimental basis to create a positive atmosphere. The private sector should be encouraged to participate, as well.

For example, in Maryland, a few weeks ago, the governor announced $70,000 in funding to the Maryland Office on Aging to establish a Health Insurance Counseling and Advocacy Program for seniors which will train volunteers in rural areas to provide help in selecting insurance, filing claims and appealing Medicare decisions.

In addition, the state should encourage employers to develop flexible employment policies that enable employees to continue to care for their older loved ones while still maintaining their level of productivity at work. Furthermore, as was indicated earlier, public education on long-term care financing options should be enhanced and state-sponsored.

South Carolina, you are to be applauded on the progress with the Bingo Tax legislation. However, as others have indicated, more is needed. Arkansas, for example, with demographics similar to the state of South Carolina, is proposing legislation to tax cigarettes to provide expanded alternatives to nursing home care. Taxing cigaretts at a nickel per package is raising about $15 million per yer for that state.

You and I are proud South Carolinians. We are a state with a rich heritage and a promising future, from the mountains to the seashore. However, we cannot, and I repeat cannot, allow states such as Maryland, Connecticut and Pennsylvannia, be constantly ahead of us in policies for the elderly. After all, it is THEY who send their retirees to US! We cannot disappoint

them or ourselves. South Carolina should be a model, nationally, for long-term care policies.

However, we are taking a step in the right direction. The South Carolina Commission on Aging has just awarded the Waccamaw region two discretionary grants totalling over $37,000 to demonstrate shared housing among seniors and to develop a prototype needs assessment of the elderly. It is anticipated that these grants will assist us in fine-tuning the issues related to older adults. Particularly, the shared housing project has as its major objective to prolong institutionalization of our older citizens by pairing them with someone who can assist them with houshold chores, as well as to provide companionship.

Yes, we have along way to go. But I challenge you, members of the Joint Legislative Committee on Aging, to NOT only hear the testimonies, to NOT only read the statistics, but go out into the field and SEE what we're talking about. Yes, go into some of the homes where, in all probability, a remnant of a human being awaits his/her social security check to pay for medicine, and meanwhile the hunger pangs consume his emaciated body. And while you're on the field, help dry the tears from the eyes of the frail woman who has just wiped out her savings and sold her home to place her husband in a substandard nursing home. It's an experience you'll never forget.

The irony of it is, if something is NOT done, that remnant of a human being could be your mother, your father, you.... or me.

Dr. Jack H. Boger, AARP
1420 Alexander Rd.
Rock Hill, SC 29730

MY NAME IS JACK BOGER AND I AM THE CHAIRMAN OF THE SOUTH CAROLINA STATE LEGISLATIVE COMMITTEE (SLC) OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP). THE SLC IN SOUTH CAROLINA IS AUTHORIZED TO SPEAK FOR THE AARP MEMBERSHIP ON STATE LEGISLATION OR REGULATORY MATTERS. OUR PRINCIPAL RESPONSIBILITY IS TO PROPOSE, INITIATE AND SUPPORT/OR OPPOSE LEGISLATIVE PROPOSALS AND POLICIES IN THE INTEREST OF THE STATE'S SENIOR CITIZENS. AARP HAS OVER 307,200 MEMBERS IN THE STATE OF SOUTH CAROLINA.

EACH YEAR THE SLC CONDUCTS A STATEWIDE SURVEY AMONG ITS MEMBERSHIP TO DETERMINE THEIR PRINCIPAL LEGISLATIVE CONCERNS. BASED ON THIS YEAR'S SURVEY, THE SLC HAS IDENTIFIED FOUR MAJOR LEGISLATIVE PRIORITIES FOR WHICH WE SEEK SUPPORT. THEY ARE:

1. EXPAND STATEWIDE COMMUNITY SERVICES TO DELAY OR PREVENT INSTITUTIONALIZATION OF FRAIL ELDERLY. SERVICES MAY INCLUDE HOME HEALTH CARE, TRANSPORTATION, HOMEMAKER SERVICES, HOME-DELIVERED MEALS, RESPITE CARE, AND ADULT DAY CARE.

2. SUPPORT CHANGES IN MEDICAID AND STATE REGULATIONS TO PREVENT THE IMPOVERISHMENT OF THE NON-INSTITUTIONALIZED SPOUSE.

3. ENACT STANDARDS FOR COMPREHENSIVE LONG TERM CARE INSURANCE POLICIES THAT ADEQUATELY PROTECT CONSUMERS.

4. RESTRAIN THE RISE OF HEALTH CARE COST IN SOUTH CAROLINA.

I WOULD LIKE TO COMMENT BRIEFLY ON EACH OF THESE.

COMMUNITY-BASED SERVICES

THE PRIORITY DEALING WITH EXPANDING STATEWIDE SERVICES TO DELAY OR PREVENT INSTITUTIONALIZATION OF FRAIL ELDERLY HAS BEEN AMONG THE TOP PRIORITIES OF OUR COMMITTEE FOR THE PAST THREE YEARS. COMMUNITY-BASED SERVICES TO ASSIST MANY FUNCTIONALLY IMPAIRED ELDERLY PERSONS IN LIVING HAPPY AND REASONABLY INDEPENDENT LIVES IN THEIR OWN HOMES OR IN THE HOMES OF RELATIVES OR CAREGIVERS HAVE BEEN EXPANDED IN RECENT YEARS THROUGH SUCH INITIATIVES AS THE COMMUNITY LONG TERM CARE PROGRAM OF THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION FOR ELDERLY DISABLED PERSONS WHO ARE ELIGIBLE FOR MEDICAID, THE ALTERNATIVE CARE FOR THE ELDERLY PROGRAM OF THE COMMISSION ON AGING, AND THE HOME HEALTH SERVICES PROGRAM OF THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL, THE LATTER TWO OPEN TO ALL BASED ON ABILITY TO PAY. WE BELIEVE A QUALITY STATE PROGRAM OF HOME AND COMMUNITY BASED SERVICES SHOULD HAVE AN EDUCATIONAL FUNCTION TO INFORM THE PUBLIC ABOUT THE ARRAY OF SERVICES AVAILABLE, AND SHOULD PROVIDE SERVICES TO AID FAMILIES CARING FOR CHRONICALLY

IMPAIRED ELDERLY RELATIVES. THE COORDINATION OF EFFORTS AMONG THE SEVERAL AGENCIES PROVIDING SERVICES REQUIRES CONSTANT ATTENTION TO ASSURE MAXIMUM AND EFFICIENT USE OF RESOURCES.

WE APPLAUD THE LEGISLATIVE AND BUDGETARY ACTIONS OF THE PAST YEAR IN SOUTH CAROLINA WHICH RESULTED IN ADDITIONAL REVENUE FOR ALTERNATIVE CARE OF THE ELDERLY, BUT FOR NEEDS TO BE MET STATEWIDE, CONSIDERABLE ADDITIONAL FUNDING WILL BE REQUIRED.

FOR THE COMING YEAR AARP WILL COOPERATE WITH OTHER INTERESTED VOLUNTEER GROUPS AND STATE AGENCIES IN EFFORTS TO FIND SUBSTANTIAL AND BUDGETARILY SOUND ADDITIONS TO PRESENT FUNDING FOR HOME AND COMMUNITY-BASED ALTERNATIVES TO INSTITUTIONALIZATION.

PREVENT IMPOVERISHMENT OF NON-INSTITUTIONALIZED SPOUSE

CHANGES IN MEDICAID AND STATE REGULATIONS TO PREVENT THE IMPOVERISHMENT OF THE NON-INSTITUTIONALIZED SPOUSE HAVE BEEN THE FOCUS OF MUCH ATTENTION NATIONWIDE. AARP SUPPORTS THE STATE PLAN PREPARED BY THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION. THIS PLAN HAS MANY EXEMPLARY FEATURES: ENHANCING PREVENTIVE HEALTH SERVICES; EXPLORING ALTERNATIVE METHODS OF HOME AND COMMUNITY-BASED HEALTH CARE DELIVERY; IMPROVING MANAGEMENT CAPABILITIES FOR MEDICAID PROGRAMS; AND RECOMMENDING STEPS TO MAXIMIZE THE COST BENEFIT RATIO OF MEDICAID PROGRAMS.

THE STATE PLAN CALLS FOR AN END TO SPOUSAL IMPOVERISHMENT BY 1992. WE UNDERSTAND THE COMMISSION WILL REVIEW OPTIONS FOR A STATE PROGRAM RELATING TO SPOUSAL IMPOVERISHMENT BY NOVEMBER, 1987.

SPOUSAL IMPOVERISHMENT IS AN IMMEDIATE AND SEVERE THREAT TO MANY ELDERLY WHO HAVE SPOUSES IN NURSING HOMES. NATIONAL STUDIES SHOW THAT MANY RETIRED COUPLES WITH AVERAGE LOWER MIDDLE CLASS INCOMES WILL BECOME IMPOVERISHED WITHIN THREE TO FOUR MONTHS OF ONE SPOUSE'S ADMISSION TO A NURSING HOME.

WE URGE THE STATE TOWARD SPEEDY ACTION FOLLOWING THE NOVEMBER REVIEW OF STATE OPTIONS. WE PARTICULARLY RECOMMEND SERIOUS CONSIDERATION OF THE OPTION INVOLVING SPLITTING COUPLE'S INCOME AND ASSETS IN WAYS THAT WILL PROVIDE THE SPOUSE REMAINING AT HOME WITH ENOUGH MONTHLY INCOME TO SURVIVE ABOVE THE POVERTY LEVEL. WE REALIZE THIS APPROACH IS NOT FREE OF COSTS TO THE STATE, BUT IT SEEMS THE ONLY OPTION THAT HAS BEEN AT ALL EFFECTIVE, AS DEMONSTRATED IN THE FEW STATES THAT HAVE ADOPTED THIS STRATEGY.

LONG TERM CARE INSURANCE

THE NEED FOR LONG TERM CARE SERVICES AND THE MEANS TO PAY FOR THEM THROUGH SOME TYPE OF LONG TERM CARE INSURANCE ARE AMONG THE MOST IMPORTANT ISSUES FACING THE COUNTRY AS WELL AS THE STATE OF SOUTH CAROLINA. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES PREDICTS THAT BY THE YEAR 2000 ONE IN FOUR AMERICANS WHO RETIRE

WILL EVENTUALLY ENTER A NURSING HOME.

THE NURSING HOME POPULATION, NOW AT 1.2 MILLION NATIONALLY, IS EXPECTED TO DOUBLE IN THE NEXT 14 YEARS.

IN SOUTH CAROLINA, THE OVER 65 POPULATION IS GROWING TWICE AS FAST AS IN THE NATION AS A WHOLE. ALSO, THE POVERTY LEVEL IN THE STATE - 23 PERCENT OF THE POPULATION - IS HIGHER THAN THE NATIONAL AVERAGE. SUCH A HIGH POVERTY LEVEL INCREASES THE POTENTIAL IMPACT ON THE STATE'S MEDICAID FUNDS.

AARP BELIEVES THAT LONG TERM CARE INSURANCE, IF SUFFICIENTLY ENCOURAGED AND FAIRLY MARKETED TO CONSUMERS, CAN HELP PROTECT OLDER SOUTH CAROLINIANS AGAINST THE COSTS OF LONG TERM ILLNESS, PRESERVE THE ASSETS OF INDIVIDUALS, AND REDUCE THE NEED FOR GOVERNMENTAL SUPPORT.

THE SOUTH CAROLINA SLC SUPPORTS H. 2673 AND S. 603, PENDING BILLS THAT WOULD IMPLEMENT THE LONG TERM CARE INSURANCE MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. THIS LEGISLATION, IF ENACTED, WOULD PROTECT APPLICANTS FOR LONG TERM CARE INSURANCE, ESTABLISH STANDARDS FOR LONG TERM CARE INSURANCE POLICIES, PROMOTE PUBLIC UNDERSTANDING OF SUCH POLICIES, AND ENCOURAGE INNOVATION IN THE DEVELOPMENT OF INSURANCE COVERAGES.

AARP SUPPORTS AMENDMENTS TO THE PROPOSED LEGISLATION THAT WOULD PROVIDE FURTHER SAFEGUARDS FOR CONSUMERS.

AARP SEEKS TO JOIN WITH OTHER CONSUMER GROUPS AND THE INSURANCE INDUSTRY IN PRESSING FOR ENACTMENT OF THIS VITAL LEGISLATION.

RESTRAINING RISE OF HEALTH CARE COSTS

THIS IS THE FOURTH YEAR THAT RESTRAINING THE RISE OF HEALTH CARE COSTS HAS BEEN ON OUR COMMITTEE'S LEGISLATIVE AGENDA. DURING THE PAST YEAR, AARP HAS BEEN REPRESENTED ON THE HEALTH INFORMATION ADVISORY COMMITTEE CREATED BY THE JOINT LEGISLATIVE HEALTH CARE PLANNING AND OVERSIGHT COMMITTEE. THE HEALTH INFORMATION ADVISORY COMMITTEE DEVELOPED POLICY AND PROCEDURAL RECOMMENDATIONS FOR COLLECTING, ANALYZING, AND DISSEMINATING HOSPITAL DATA RELATED TO COSTS OF CARE. THE HEALTH INFORMATION ADVISORY COMMITTEE HAS DEVELOPED A PLAN FOR HOSPITAL COST DATA DISSEMINATION TO CONSUMERS, PROVIDERS, INSURERS, GROUP PURCHASERS, AND STATE GOVERNMENT.

WE CONCUR WITH THE SOUTH CAROLINA STATE POLICY EXISTING SINCE 1976 THAT THE OPEN PUBLICATION OF HOSPITAL FEE SCHEDULES SHOULD BE GIVEN FAIR TRIAL AS A COST CONTAINMENT INCENTIVE. BEFORE RESORTING TO MORE RESTRICTIVE MEASURES SUCH AS LEGISLATIVE PRICE REGULATION.

THE MEDICALLY INDIGENT ASSISTANCE ACT (MIAA) IS NOT ONLY AN EXCELLENT PACKAGE OF LEGISLATION TO ASSIST THE MEDICALLY INDIGENT, BUT ALSO PROVIDES GUIDFLINES FOR THE CONTINUOUS

DEVELOPMENT OF A COMPETITIVE MODEL FOR THE STATE HEALTH CARE SYSTEM AIMED AT RESTRAINING RISES IN HEALTH CARE COSTS.

AARP WILL SUPPORT THE JOINT LEGISLATIVE HEALTH CARE PLANNING AND OVERSIGHT COMMITTEE IN ITS EFFORTS TO OBTAIN MORE ADEQUATE FUNDING FOR ALL COMPONENTS OF THE MEDICALLY INDIGENT ASSISTANCE ACT SO THAT THE NEEDS OF THE MEDICALLY INDIGENT MAY BE MORE ADEQUATELY ADDRESSED, AND THE COMPETITIVE MODEL FOR HOSPITAL COST CONTAINMENT MAY BE MORE FULLY IMPLEMENTED. WE AGREE WITH THE MIAA LANGUAGE WHICH SPECIFIES "RISING HEALTH CARE COST AND THE GROWTH OF THE MEDICALLY INDIGENT POPULATION HAVE INCREASED THE STRAINS ON THE HEALTH CARE SYSTEM WITH A GROWING BURDEN ON THE HOSPITAL INDUSTRY, HEALTH CARE INSURANCE COMPANIES, AND PAYING PATIENTS." WE ALSO STRONGLY SUGGEST THAT THE CLOSE SCRUTINY POSTURE PRESENTLY PURSUED RELATIVE TO HOSPITAL COSTS BE MORE FULLY EXTENDED TO OTHER MEMBERS OF THE HEALTH PROVIDER COMMUNITY, SUCH AS NURSING HOMES, PRIVATELY OWNED COMMUNITY-BASED SERVICES, PHYSICIANS, AND HEALTH CLINICS. LAST YEAR, HEALTH CARE COSTS INCREASED AT FOUR TIMES THE GENERAL INFLATIONARY RATE.
WITH RENEWED INFLATION, WE CAN EXPECT EVEN GREATER MEDICAL COSTS THIS YEAR.

OTHER SPECIFIC ITEMS

IN ADDITION, AARP WILL CONTINUE SUPPORT TO:

- INCREASE HOMESTEAD ALLOWANCE FOR ELDERLY HOMEMAKER FROM $20,000 TO $30,000

- PROVIDE AN INCREASE FOR RETIRED STATE EMPLOYEES AND TEACHERS WHO HAVE BEEN RETIRED THE LONGEST IN MAKING POST-RETIREMENT ADJUSTMENTS.

WE WISH TO THANK THE STATE LEGISLATURE FOR ITS EFFORTS ON BEHALF OF OLDER CITIZENS IN SOUTH CAROLINA. DESPITE THE MONEY CRUNCH, WE FEEL REAL PROGRESS WAS MADE THIS YEAR IN SUCH AREAS AS SUPPORT FOR COMMUNITY-BASED SERVICES, ADDITIONAL FUNDING FOR NURSING HOME PROVIDERS, AUTHORIZATION OF PROGRAMS TO EDUCATE CITIZENS CONCERNING HEALTH CARE PROBLEMS OF THE ELDERLY, THE ESTABLISHMENT OF THE LONG TERM CARE COUNCIL, AND THE NEW REGULATIONS FOR HEALTH MAINTENANCE ORGANIZATIONS. THANK YOU FOR THE PRIVILEGE OF PRESENTING THE LEGISLATIVE PROGRAM OF SOUTH CAROLINA AARP.

Kay Jamerson-McDonagh
S.C. Assn. of Council on Aging Dir.
P.O. Box 832
Sumter, SC 29151

PUBLIC HEARING TESTIMONY

JOINT LEGISLATIVE COMMITTEE ON AGING

OCTOBER 7, 1987

S.C. ASSOCIATION OF COUNCIL ON AGING DIRECTORS

Today, The South Carolina Association of Councils on Aging wishes to pay tribute to you for your accomplishments during the last legislative session, particularly as those efforts are reflected by your success in securing designation of part of the Bingo Tax Revenue for aging services. Our bouquets to you represent our personal celebration of the beginning of a permanent financial base for in-home supportive services. Each council on Aging throughout the state realized that the hard work, negotiations, compromises and maneuvering you did to obtain passage of the legislation was no easy task. But you need to know that we were behind you 100%. And we will be behind you again as we continue our partnership to secure an adequate and permanent financial base for in-home supportive services to South Carolina's health impaired older citizens.

Like never before in America's history, we are faced with a decision about our future - for us and for the older population. As families and communities have changed their pattern of caring for older persons, so have agencies. Councils on Aging have advanced over the past few years in their ability to help families as they help their aging relatives. But we are still far from being prepared to help the 19,000 people who need services now; nor are we ready for the explosion of older persons that is projected within the next thirty (30) years.

As we look back over the successes of the past years - particularly to the success of last year - some may feel that it's time to give it a rest, to "coast" for a year or so and see what happens.

Ladies and Gentlemen, Councils on Aging throughout the state just don't believe we can afford to do that.

Let me give you a few examples of the current situation regarding services and the older citizens of South Carolina.

In Newberry County, 102 people are currently on waiting lists for home delivered meals, respite care or homemaker services. This number does not even reflect those who live in unserved areas of the county. Also, to get on a waiting list, the person has to qualify with all eligibility criteria - i.e., they have been screened, their needs assessed, other resources tapped, etc. The full gamut has been tried and yet the only thing that can be done is to add their name to a list in hopes that either funds will increase, or a slot becomes available before a client reaches the point of requiring more expensive, alternative care in institutions... or the person dies. That's a sad tale, but the truth of the matter is that more and more often a client will die shortly after receiving his or her first home delivered meal or first homemaker visit. Some may say that the client who dies that soon after initiating in-home services would not have benefited from the service anyway; but, the positive results we have seen when services were initiated at an appropriate time and in sufficient quantity leads us to believe that in-home services can and do make a difference.

Another example is in Greenville County. The Council on Aging has 33 people on the waiting list for homemaker services. These thirty-three are waiting for a service which is only available even in the worst situations to two three-hour visits per month. Since the number of available units of service is spread so thin in an attempt to help more people, most have only one visit per month. That's very little help when, in many cases, the homemaker's assistance of grocery shopping and housekeeping can be the link to a person remaining at home rather than being placed in a nursing home. The cost differential would make a significant impact on the state budget.

In the Aiken area, over 30 people are waiting for home-delivered meals, some since April of this year. Individuals on the list have been referred by doctors, nurses, caseworkers, family members or the individual has called on their own behalf.

In each cases the person has legitimate health limitations which prohibit their own preparation of meals even if they have enough income to purchase the variety of foods necessary for nutritious meals, or the means to obtain the food, or the emotional desire to cook for themselves and sit down to eat alone.

In Pickens County, where the Council on Aging budget is stretched to the limit, more and more new clients are being discharged early from nursing homes and hospitals and need in-home supportive services, but none are available. This is a direct result of the initiation of Diagnostic Related Groupings or DRG's as we have come to refer to it. Recipients of in-home services at the present time were cared for in acute care hospitals only 3-4 years ago.

Rezoning in Allendale has netted a waiting list of fifty people for either transportation, homemaker services, home-delivered meals, or respite care. The Council on Aging there accepts its responsibility of serving the senior adult population but without adequate funding, must deny or delay services to people in real need of help.

Several areas in the State have been mentioned by name but you will find similar situations throughout the state. These examples only represent a small portion of the current state of senior citizen services available across South Carolina.

Someone once said that you can judge the quality of a society by the way they treat their old. We hope that you will allow us to join with you again next year and work as hard as last year to continue a progressive approach to eradicating the types of situations just described.

How do we do it? How do we prepare for the future influx of seniors and at the same time eradicate those on a waiting list with a verified need for services? Councils on Aging in South Carolina think that we can do it. We think we can help those in need, that we can provide quality services at a cost that does not break the State or Federal budget, and that we can develop new and better ways to help families continue helping their older relatives longer.

We need at least $2.1 million dollars to make the initiative possible. This funding, added to the continuing state appropriation for community services and the bingo tax revenue, will allow county service providers to better and more appropriately serve those in need. It will also allow for sufficient funds to continue the support and growth of innovative programs to assist family caregivers such as a wider spread of respite care programs and family caregivers' training programs and support groups.

It will also begin to reverse the trend of supporting institutional care over in-home services. We do believe that the level of care offered by nursing homes in intermediate and skilled care facilities is a valuable community resource and when appropriate, should be utilized. But our system of caring for older persons has for too long been geared toward funding of institutional care when in many cases in-home services are the preferred alternative and can be less expensive. Our current system does not allow the choice. If services are not available in the community, then nursing homes become the only way to survive.

We also support and encourage your support for passage of Long Term Insurance to assist with payments for nursing home care when appropriate. We strongly feel that it should include coverage for in-home support services. Long Term Care insurance can help ease the strain on the state budget and will allow individual choice in selecting care alternatives. This insurance can support the trend of reversing our current funding priorities to the preferred choice of in-home care. For those who can afford the insurance protection, both institutional and in-home support systems would benefit by reducing the reliance on State and Federal funding. For those who cannot afford this insurance coverage, the publicly supported community support services and Medicaid programs will provide the appropriate level of care if increased funding is made available now.

Our continued partnership and your willingness to lead the fight for what is right can produce a society in South Carolina that is judged to be a quality society.

$2.1 million and support of Long Term Care insurance are our plea. Our pledge is that we will work behind the scenes to support your efforts in the legislature and then we will work diligently to deliver the best quality of services at the least possible cost.

Thank you very much.

Kay Jamerson-McDonagh
President, SC Association of
Council on Aging Directors

Sumter County Council on Aging
PO Box 832
Sumter, SC 29150
(803) 773-5508

Rep. Waldrop - Thank you ma'am. I'm sure every member appreciates the ballons and the paperweights that say "SC Association of Council on Aging Directors.
- a little memento that we can use to weigh down these bills!

Samuel T. Waldrep, Treasurer
S.C. Gerontological Society
218 S. Saluda Ave.
Columbia, SC 29205

Joint Legislative Study Committee on Aging
Public Hearing
October 7, 1987

Testimony presented by Sam Waldrep on behalf of the South Carolina Gerontological Society.

My name is Sam Waldrep. I am here today representing the Board of Directors and members of the South Carolina Gerontological Society. The Society, which will be celebrating its 10th anniversary this year, is dedicated to promoting advancements in gerontology in the state through education, training, advocacy and coordination. We now have chapters in Greenville, Columbia, Florence, Charleston and Aiken and a sixth one being organized in Rock Hill to further our work.

One of the Society's main goals has been to increase knowledge in the area of gerontology. To this end, we have long been concerned that almost no job descriptions for positions involving work with older persons is there any reference to gerontological training. One of the criteria for recognizing a profession is that a person who aspires to practice in that occupation will have received appropriate training. While 75 years ago one could be apprenticed to a lawyer and then hang out a shingle and practice law, today you are required to attend law school and pass a BAR examination before you can consider calling yourself a lawyer. To be employed as a nursery school or kindergarten teacher in an accredited institution you must also be trained in early childhood education. Yet there is no similar recognition granted to professionals who work with aging clients.

The requirements for various positions in state government come from the departments of the employing agencies. Many of these departments may not even be aware that training in gerontology has become more readily available in South Carolina as well as in other states.

The Joint Legislative Study Committee on Aging as the premier body concerned with legislation impinging on the elderly should consider efforts to promote the training of employees whose primary responsibility is to deal with older persons. The Society supports measures which would encourage official consideration in employment practices to persons who have training in gerontology.

Also directly related to our goal in increasing understanding of gerontology is our interest in promoting research. Our state is blessed with an excellent network of professionals and institutions of higher education that are dedicated to research endeavors. The Society endorses that segment of the South Carolina Commission on Aging's 1988-89 budget request which would allocate discretionary funds for research.

In other legislative matters, the South Carolina Gerontological Society adds its endorsement to the following measures:

1) H.2673 and S.603 were introduced last year to set standards for long term care insurance. The growing numbers of older South Carolinians coupled with problems in financing long term care make it necessary for our state to allow individuals to privately purchase long term care insurance with appropriate consumer safeguards. Regulated long term care insurance has the potential of protecting older South Carolinians against escalating long term care costs and can reduce the need for government support for such cases.

2) S.379, which passed in the Senate last year, would repeal state mandatory retirement provisions. If enacted, this bill would allow older workers the opportunity to remain gainfully employed and would abolish mandatory retirement on the basis of age alone.

3) Establishment of a Dementia Registry for the state is desperately needed for a data base for planning health and social services for these individuals. Currently there is a lack of reliable data to determine the incidence of dementia, the characteristics of this population and their needs.

4) The state needs to seek measures to alleviate spousal impoverishment in cases where a married person applies for Medicaid coverage. Medicaid, the very program designed to help the poor, often forces many older persons into dire poverty due to complex eligibility rules.

The South Carolina Gerontological Society would appreciate your careful consideration of the matters that I have brought before you. And, in closing, I extend an invitation to each of you to attend our upcoming annual meeting on October 28-30 here in Columbia. This year, the Society is combining efforts with the South Carolina Federation of Older Americans to present an informative session entitled "Shaping the 90's Together."

Again, I appreciate your attention and consideration.

Dr. Ernest Furchtgott, Dir.
S.C. Gerontology Center
USC - Barnwell College
Columbia, SC 29208

TESTIMONY PRESENTED TO

JOINT LEGISLATIVE COMMITTEE ON AGING

SOUTH CAROLINA GENERAL ASSEMBLY

October 7, 1987

by Ernest Furchtgott, Ph.D. Director

South Carolina Gerontology Center

Chairman Waldrop ~~Harris~~, Members of the Committee and staff I would like to express my appreciation for giving me the opportunity to testify before your Committee. I have appeared before you for the last several years since you are the spokespersons for the field of aging in our legislature and thus the representatives of the people of South Carolina.

The South Carolina Gerontology Center was established in January 1985 as a consortium of several state supported institutions of higher education to promote research and education in aging. The rationale for a consortium was to minimize duplication of activities and thereby reduce costs. Initially, the consortium members agreed to share the costs of operating the Center. After the first year, however, several of the member institutions, facing tight budgets, decided not to contribute even the few thousand dollars of their share of operating the Center. Thanks to Senator

Lourie and others the Legislature did approve for fiscal years 1986/87 and 1987/88 amendments to USCs budget of $25,000 each year to operate the Center. However, the 1987/88 bill also stipulated that for the future the Center should go through the normal USC appropriation request for the funding of the Center. This the Center did and USC also did request for 1988/89 an item for the operation of the Center. However, when USC's budget was reviewed by the Commission on Higher Education they vetoed this item despite our documentation of our accomplishments and data of a survey conducted three years ago which showed that most states had at least one, many several, gerontology centers at state supported institutions with a median budget from state funds of over $70,000. For example, Georgia supports two centers, one at the University of Georgia and the other at Georgia State University. The former's state appropriation is well over $100,000. They have a director at the professor level and an associate director at the associate professor level half of whose salaries come from Center funds.

Since the Center was established less than three years ago we have published annually a directory of research personnel in gerontology, a directory of data bases on older South Carolinians, quarterly newsletters, we have provided support to various individuals in writing grant

applications, and served as a research referral source on gerontology to various state agencies. I, as the Director have represented the Center on various study committees in gerontology, and given numerous talks on aging.

I respectfully request that your Committee study state funding of gerontological education and research in our institutions of higher education and perhaps also some of the other state agencies which serve our older population. It seems almost unnecessary to indicate that the well being of older persons and the public's attitudes and perception and thus policy are greatly influenced by education and research and in these activities our institutions of higher education play a major role. I hope that such a study can be completed in time for some legislation to be acted upon during the next legislative session.

Rep. Blackwell - Dr. Furchgott, they just took you out of the budget completely?

Furchgott - I'm volunteering all of my services here.

Rep. Blackwell - Higher Education folks are the ones that did it? USC did it? Who?

Furchgott - Higher Education says No. Gerontological study isn't necessary and I also checked with Clemson. There's no appropriation at Clemson for Gerontology.

S.C. Adult Day Care Associatio
Dept. of Social Services
P.O. Box 1520
Columbia, SC 29202

THANK YOU MR. CHAIRMAN, MEMBERS OF THE JC STUDY COMMITTEE ON AGING, STAFF AND OTHER PERSONS ATTENDING THIS VERY IMPORTANT PUBLIC HEARING. I AM CARRIE SINKLER-PARKER, PRESIDENT OF THE SOUTH CAROLINA ADULT DAY CARE ASSOCIATION, INCORPORATED.

THE SOUTH CAROLINA ADULT DAY CARE ASSOCIATION COMMENDS YOU AND YOUR COMMITTEE FOR THE WORK DONE ON BEHALF OF THE ADULT POPULATION IN OUR STATE.

ADULT DAY CARE FACILITIES HAVE EXISTED IN SOUTH CAROLINA SINCE 1975. OUR STATE IS ONE OF THE FIFTEEN (15) STATES IN THE UNITED STATES THAT REQUIRES ADULT DAY CARE FACILITIES TO BE LICENSED. COPIES OF SOUTH CAROLINA'S LICENSING REGULATIONS HAVE BEEN SHARED WITH OTHER STATES WHO ARE CONSIDERING LICENSURE REQUIREMENTS. THE ASSOCIATION IS PROUD THAT THE SOUTH CAROLINA GENERAL ASSEMBLY HAD VISION AND FORTHRIGHTNESS TO ENACT A LICENSING REGULATION THEREBY ENSURING ADULT DAY CARE FACILITIES MEET STANDARDS BEFORE AND DURING THE LIFETIME OF THEIR OPERATION.

ADULT DAY CARE FACILITIES HAVE INCREASED IN OUR STATE AND CONTINUE TO INCREASE ANNUALLY. IN 1984, THERE WERE FIVE (5) ADULT DAY CARE FACILITIES SERVING ONE HUNDRED NINETEEN (119) FRAIL AND DISABLED ADULTS. TODAY, THERE ARE TWENTY-TWO (22) LICENSED FACILITIES SERVING SOME SEVEN HUNDRED (700) ADULTS WHO NEED SUPERVISION IN ORDER TO REMAIN IN THEIR OWN HOMES AND COMMUNITIES.

MEMBERS OF THE ASSOCIATION HAVE ENJOYED A COOPERATIVE WORKING RELATIONSHIP WITH THE OFFICE OF HEALTH CARE LICENSING, DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL (DHEC). AFTER CAREFUL DELIBERATION AND CONSIDERATION, WE WOULD LIKE TO MAKE THE FOLLOWING RECOMMENDATIONS: (1) THAT THE OFFICE OF HEALTH CARE LICENSING, DHEC, GIVE TOP PRIORITY TO REVIEW AND/OR REVISION OF THE LICENSING REGULATIONS FOR ADULT DAY CARE AND (2) THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING REQUEST THAT THE SOUTH CAROLINA ADULT

DAY CARE ASSOCIATION SERVE AS THE ADVISORY COMMITTEE TO DHEC DURING ITS REVIEW AND/OR REVISION PROCESS OF THE LICENSING REGULATIONS FOR ADULT DAY CARE.

MR. CHAIRMAN, THIS CONCLUDES OUR PRESENTATION. I WILL BE HAPPY TO ENTERTAIN ANY QUESTIONS FROM YOU, MEMBERS OF THE COMMITTEE OR STAFF.

AGAIN, THANK YOU MR. CHAIRMAN AND MEMBERS OF THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING.

Hearing was recessed at 12:30 for lunch.

Hearing reconvened at 1:30 p.m.

Rep. Waldrop - One gentleman has walked in that is a former representative just recently retired whose going to be a lobbyist. He has served here for some nine years. Is that correct Derial? Former Representative Derial Ogburn. I'd like for you to stand up sir and be recognized. He has always been a supporter of ours.

Rep. Blackwell - Thank you Mr. Chairman, I would like for those of you here who are professionals to meet Mr. Pat Mason who is the Executive Director of SC Retirement Communities Association. Stand up Pat. This man is one of the most enthusiastic folks involved in retirement communities. If you ever need help, call on Pat Mason to come talk with you. He's an asset to this state and we are going to make South Carolina a retirement state with his help. Thank you for being here, Pat.

Rep. Waldrop - Thank you, Rep. Blackwell. I'd like to at this time before we get into our formal agenda to mention briefly that House - Labor, Commerce, and Industry Sub-committee is having a public hearing on H.2673 - the Long Term Care Insurance Act. The next Public Hearing is Thursday, October 22nd in Greenville. If you need further information on this, you can contact Ms. Barron.

Claude Vaughn
3932 Dubose Dr.
Columbia, SC 29204

SOUTH CAROLINA FEDERATION OF OLDER AMERICANS
101 CAROLINA CIRCLE
WEST COLUMBIA, SOUTH CAROLINA 29169

28 September 1987

To: Joint Legislative Committee on Aging

Re: Recommended Legislative Priorities for 1988

From: SCFOA Legislative Forum

The Legislative Forum at its meetings of August 18 and September 16 recommended the following legislative priorities for 1988.

LONG TERM CARE INSURANCE. This is the major concern of the Legislative Forum.

Others are as follows:

MARRIAGE LICENSE INCREASE to provide revenue for expanded services for the impaired elderly.
Question: Should there be a divorce license?
Rationale: Alternatives to nursing home care should be encouraged and financed whenever possible.

HOMESTEAD EXEMPTION INCREASE TO $30,000.
Rationale: We believe that retirees should be able to remain in their homes if they so desire and should not be forced to sell because of increasing property taxes.

MOBILE HOME OWNERS PROTECTION.
Rationale: We believe that mobile home owners should have the protection of a written contract which safeguards fees, services, and continued use of the site.

TAX CONCESSIONS FOR CITIZENS WHO CHOOSE HOME CARE OVER NURSING HOME CARE WHEN THEY BECOME FRAIL AND DEPENDENT.

Presented by Claude Vaughn, Program Chairman, South Carolina Federation of Older Americans Legislative Forum.

Daniel J. O'Neal III
S.C. Nurses' Association
College of Nursing - USC
Columbia, SC 29208

South Carolina Nurses' Association
1821 GADSDEN STREET
COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE 252-4781

October 7, 1987

STATEMENT BEFORE THE JOINT LEGISLATIVE COMMITTEE ON AGING

My name is Daniel J. O'Neal III, R.N., and I represent the South Carolina Nurses' Association, which is the state affiliate of the American Nurses' Association. The state nurses' association Council on Gerontological Nursing represents those registered nurses in the state who have expressed special interest in older adults either because we work with older adults, we teach about older adults, we are older adults, or all of the above.

The purpose of our organization in appearing before this body today has a request behind it that may not seem evident at first. I will describe some achievements nurses have made which benefit older adults directly or indirectly. We recognize that certain aspects of our health care system are problematic for older adults in our society. We believe that by representing the work of nursing practice, nursing education and nursing research we can demonstrate to you that nurses are ready and willing to be part of the solution to problems affecting older adults.

The first accomplishment our organization would like to describe is the work done by nurses in measuring quality of health care. Nurses took the lead in the 1970s in investigating quality of care and today the literature about quality of nursing care is more advanced and extensive than comparable literature for any other aspect of patient care (GAO/PEMD-87-15BR, Medicare: Strategies for Assessing Quality of Care, July, 1987). So early was this work in measuring quality of care that a concensus conference was held in Washington as far back as 1971 to refine data elements that are needed to measure quality of nursing care. What nursing is now doing with respect to quality of care is study what determines the relationships among quality of care and cost of care, a critical issue in this day of prospective payment systems. The bottom line for quality of nursing care is that nurses continue to be willing to examine nursing practice and to change it, to meet what older adults deem to be higher quality of care.

Closely related to quality of care is the nursing profession's willingness to determine for itself the standards of professional practice which form the basis for evaluating how the professional nurse implements knowledge. The national gerontological nursing standards were the very first published by the American Nurses' Association among the sub-specialties of nursing like medical-surgical, maternity, pediatric, community health and others. These standards have been in

place for twelve years as a guide for each individual nurse to evaluate his/her professional practice. Though comprehensive, they are under revision and are due out soon in a more usable format.

There are a variety of initiatives which nurses in this state and in the Southeast have implemented to try to address needs of older adults and our commitment to the exuberant well being of older adults. Among those initiatives are the training programs in place for nurses. Each of the three graduate programs in nursing in this state has a defined gerontological nursing track/emphasis area which prepares gerontological nurses at the master's degree level. National accreditation criteria for schools of nursing require that nursing programs at all levels (associate, diploma and bachelors' degree) provide specific content and learning experiences with older adults. We in SC are doing our part to ensure that faculty in schools of nursing have the necessary background and knowledge needed to provide those learning experiences for other nursing students.

Another initiative on the part of nurses in this state includes the emphasis given to ongoing, post-basic (continuing) education in gerontological nursing. For 1988 we are offering the Third Annual Conference on Gerontological Nursing in Greenville. The two prior conferences in Kiawah and here in Columbia have been the setting for more than 100 nurses each to hear and discuss with the paper presenters and keynote speakers who address issues of nursing and older adults.

An initiative in nursing in this state is the involvement of many nurses in the design, as well as the implementation, of new models of health delivery. The Nursing Center at Clemson is one such example where health promotion and disease prevention are practiced by nurses in a fee-for-service setting. In Columbia, USC's College of Nursing is providing the nursing case management for a respite care, a homemaker and a sitter program in coordination with the sponsor, the Council on Aging of the Midlands. In this arrangement, the College provides well prepared nurses to assess, plan and evaluate care of frail elderly living at home, and the Council on Aging of the Midlands saves the expense of a full time nurse on its staff.

There are other accomplishments which might further demonstrate to you the willingness of nurses in the state to be part of the solution to problems of older adults. But I mentioned at the outset that this testimony has a request, albeit a hidden one. It is, to ask you to talk with a nurse today to learn more about what nursing can do and wants to do toward the exuberant well being of all citizens, young and old.

We look forward to continuing our work <u>with</u> you.

DSS Adult Protective Services
P.O. 1520
Columbia, SC 29202-1520

JOINT LEGISLATIVE STUDY COMMITTEE ON A(

PUBLIC HEARING

OCTOBER 7, 1987

DEINSTITUTIONALIZED NURSING HOME PATIENT PROJECT

MR. CHAIRMAN, MEMBERS OF THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING, OTHER INTERESTED PERSONS: ~~MY NAME~~ I am Mollie Corrie of the ~~IS MARIE DUNNAM,~~ ~~AM DIRECTOR OF ADULT SERVICES FOR~~ Adult Services Division of THE SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES.

BACKGROUND:

SOUTH CAROLINA HAS A SIGNIFICANT NUMBER OF ADULTS WHO ENTER NURSING HOMES FOR INTERMEDIATE OR SKILLED CARE AND THEN RECUPERATE TO THE EXTENT THAT THEY ARE ABLE TO FUNCTION SEMI-INDEPENDENTLY. SOUTH CAROLINA IS CONDUCTING SEMI-ANNUAL INSPECTION OF CARE REVIEWS AND UTILIZATION REVIEWS OF NURSING HOME PATIENTS. AS A RESULT OF THESE REVIEWS, SOME ADULTS FIND THAT THEY ARE NO LONGER MEDICAID ELIGIBLE FOR NURSING HOME CARE.

ON DECEMBER 1, 1986, A CONTRACT WAS ENTERED INTO BY AND BETWEEN THE STATE REORGANIZATION COMMISSION/SOUTH CAROLINA HUMAN SERVICES INTEGRATION PROJECT, AND THE SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES DEINSTITUTIONALIZED NURSING HOME PATIENTS PROJECT. THE PROJECT PROVIDES CASE MANAGEMENT TO THESE DISCHARGED PATIENTS AND COLLECTS DATA ON THEM REGARDING SERVICE NEEDS AND THE EFFECTS OF DEINSTITUTIONALIZATION.

THE DEPARTMENT EMPLOYED TWO SOCIAL SERVICES PROGRAM DIRECTORS II TO WORK ON CONTRACT IN THE ADULT SERVICES DIVISION. EACH PROGRAM DIRECTOR IS ASSIGNED TWENTY-THREE (23) COUNTIES, AND ASSISTS THE ASSIGNED COUNTIES IN DEVELOPING RESOURCES AND PLACEMENTS FOR CLIENTS DISCHARGED FROM NURSING HOMES.

OVERVIEW:

THE TWO MAJOR GOALS OF THE DEINSTITUTIONALIZED NURSING HOME PATIENTS' PROJECT ARE TO IDENTIFY THE NEEDS OF FORMER NURSING HOME PATIENTS AFTER THEIR RETURN TO THE COMMUNITY, AND TO PROVIDE CASE MANAGEMENT WHICH CONSISTS OF RECORDING CLIENT CHARACTERISTICS, SERVICES USED AND/OR THEIR CONTINUING STATUS. THOSE CLIENTS IN NEED OF DIRECT SERVICES ARE FOLLOWED BY LOCAL COUNTY DSS OFFICES, AND OTHERS ARE REFERRED TO THE STATE PROGRAM DIRECTORS FOR ON-GOING EVALUATION.

SINCE FULL IMPLEMENTATION OF THE PROJECT IN JANUARY, 1987, THE STATE LEVEL PROGRAM DIRECTORS HAVE CONDUCTED FACE-TO-FACE INTERVIEWS WITH 90% OF ALL CLIENTS. DISCHARGED CLIENTS HAVE BEEN TRACKED TO SEE THAT THEY ARE RECEIVING ALL AVAILABLE, APPROPRIATE COMMUNITY SERVICES, AND REFERRALS MADE WHEN NEEDED. THEY HAVE ALSO MAINTAINED A RECORD OF UNITS OF SERVICE PROVIDED TO CLIENTS.

CURRENT STATUS:

ONE HUNDRED EIGHTY-FOUR (184) INDIVIDUALS HAVE BEEN REFERRED TO THE PROJECT. OF THESE, ONE HUNDRED SIXTY-THREE (163) HAVE BEEN FOLLOWED BY THE STATE LEVEL PROGRAM DIRECTORS. INFORMATION HAS BEEN GATHERED ON COMMUNITY SERVICES CLIENTS ARE RECEIVING, THEIR FEELINGS ABOUT THEIR DISCHARGE, AND THEIR GENERAL CONDITION. (REFERRALS HAVE BEEN MADE FOR DSS SERVICES AS NEEDED).

AT THE PRESENT TIME, FORTY-ONE (41) CLIENTS ARE AT HOME, SIXTY-ONE (61) ARE IN RESIDENTIAL CARE FACILITIES, FIFTY-FOUR (54) ARE IN NURSING HOMES, FOURTEEN (14) HAVE MOVED OUT OF STATE, AND FOURTEEN (14) ARE DECEASED.

FUNDING FOR THE PROJECT ENDS ON OCTOBER 30, 1987, THEREFORE, THE SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES HAS RECENTLY APPLIED TOTHE STATE REORGANIZATION COMMISSION FOR SECOND-YEAR FUNDING. HOPEFULLY, FUNDING WILL BE APPROVED SO THIS CLIENT POPULATION, THE MAJORITY OF WHOM ARE 70 YEARS OF AGE OR OLDER, CAN CONTINUE TO RECEIVE THE ATTENTION THEY SO GREATLY NEED AND DESERVE.

Patricia C. Rowe
Older American Volunteer Progra
5290 Rivers Ave., Suite 300
Charleston, SC 29418

TESTIMONY

JOINT LEGISLATIVE COMMITTEE on AGIN(

October 7, 1987

by

Patricia Rowe, representing the Older American Volunteer Programs in South Carolina

Chairman Harris, ladies and gentlemen:

ACTION Older American Volunteer Programs have been present in South Carolina since 1968, yet little is known about them.

The senior volunteers who serve in the S.C. OAVP programs under ACTION, constantly, reaffirm the founding concept of citizen participation as the hallmark of a free and democratic society.

In South Carolina there are eight Retired Senior Volunteer Programs, three Foster Grandparent programs and one Senior Companion Program. All of these programs are committed to the spirit of people helping people, encouraging local volunteer efforts by channelling the energies, innovative spirit, experience and skills of the senior volunteers in meeting the needs of the community.

Today, I am addressing particularly the Retired Senior Volunteers. There are over 4,000 RSVP volunteers serving their communities in South Carolina. In 1986 these volunteers contributed 677,080 hours of their time to volunteer services. Based on minimum wage, the estimated value of these hours is $3,200, 510.00. This is a conservative figure because many volunteers possess higher paying professional skills and experience in management, education, medicine, etc.

The RSVP volunteers serve in courts, schools, museums, libraries, hospitals, hospice, nursing homes, in-home projects, day care centers, nutrition sites, and other service centers. Volunteers serve without compensation, but may be reimbursed for transportation expenses.

The program continues to expand its efforts to match resources to the diverse needs of the communities of South Carolina by providing increased opportunities for retired persons aged 60 and older to serve their communities on a regular basis in a variety of settings.

ACTION's current RSVP projects emphasize services to youth, literacy, drug abuse, in-home care, consumer education, crime prevention and management assistance to private non-profit and public agencies.

Since 1980 ACTION resources for RSVP have generally remained constant, projects have successfully generated non-ACTION resources to help expand and improve volunteer services. RSVP sponsors, their Advisory Council and staff, have used imagination and varied approaches to attract cash and in-kind contributions to match the Federal Funds given by ACTION.

It is easier to expand services with a program already in place than to re-invent the wheel. The senior volunteers have proven themselves flexible through the year. meeting the demands asked to them by their communities. Presently, RSVP is serving a small portion of the eligible senior population in South Carolina. Restraints in budgets could be alleviated with additional non-federal funds. Mandatory benefits such as insurance and transportation would have to be funded in order to include the evergrowning senior population. This we hope to address in the near future with the possibility of state funds.

More than 28 states have appropriated funds in their budgets for RSVP programs. Over 85% of the private sector support comes from non-profit community including significant support from many United Way organizations. Cash and in-kind resources are provided by community service,civic and church related organizations.

The National RSVP Participation Impact Evaluation, RSVP's most recent program evaluation, was designed to measure the benefits and effects of participation on the RSVP volunteers over time. Published in 1986, the report concludes that:

(1) RSVP involvement favorably affects Older Americans.

(2) Socially, mentally, physically and to a lesser degree economically, RSVP volunteers are better off than those who have never served in the program.

(3) Continued program participation enhances participant's own sense of well being and outlook on life and may retard the debilitating effects of aging.

In conclusion, I would like to reiterate that through the years we have all done a lot with very little working capital, but there is so much more we could do with just a little more. We would like to reach twice the number of seniors that are currently, under the RSVP program. The request for services are there, We need the manpower, but that brings us back to addition funding. With this thought we hope to be able to show you in the near future how this can become a reality.

Thank you.

Benny T. Clark, Deputy Exec. Dir.
SC Health and Human Finance Comm
1801 Main St.
Columbia, SC 29202

Good Afternoon Mr. Chairman and Members of the Committee. I am Benny Clark, the Deputy Executive Director for Programs of the Health and Human Services Finance Commission (HHSFC). The HHSFC is charged with the financing of long term care facilities. The financing of these facilities and services in South Carolina rest primarily with the State HHSFC through the Medicaid program.

In South Carolina Medicaid finances between 75-80% of the nursing home care for the elderly and disabled. This is an attractive alternative for South Carolina because the Federal Government pays approximately 73% of the Medicaid payments. However, these expenditures are competing with other financial needs of the state and the federal government is constantly seeking ways to reduce its financing of long term care needs. Nationally the Federal Government spends $25 billion, which is approximately 50% of the nations long term care expenditures.

We, at the HHSFC, would suggest that South Carolina attack the needs of our elderly citizens in a more comprehensive manner. We cannot afford to continue to defer the cost of long term care for our elderly citizens to the state's tax payers. We feel a comprehensive approach to design a long term care program that stresses the following factor is critical.

- Emphasize client choice, based on client needs and preferences.

- Encourage independence and self-sufficiency.

- Develop financial incentives for the middle class to invest in mechanisms that will enable them to pay for their long term care needs.

- Encourage private Long Term Care Insurance as a partial solution.

- Develop shared public and private funding arrangements.

- Develop alternative to institutional long term care that does not require such a large investment in brick and mortar.

- Aggressively seek and utilize federal and foundation funding to use as demonstration and seed money to develop alternative reimbursement methodologies.

Last year a study was released by the Institute of Medicine entitled IMPROVING THE QUALITY OF CARE IN NURSING HOMES. The basic focus of this report centered on the patient/client needs. It emphasizes the need to allow patients to make certain choices and to ensure that the long term care system by its design did not prevent a reasonable quality of life.

These recommendations have a considerable price tag. Once again, the issue of financing the traditional institutional long term care system as we know it places a tremendous burden on South Carolina. Regardless of the funds required, the incentives or

reimbursement principles need to be changed. The focus needs to be shifted to the quality of patient care and achieving desired patient outcomes.

We have to ensure that in South Carolina our limited resources go to benefit those truly needy, both medically/socially and financially. Once a mature citizen becomes deficient in some area of daily living activities we must not automatically assume that its time to institutionalize this person. Our support systems must be designed to give a helping hand without making the person totally dependent.

Nursing home care is expensive ($15 - $20 thousand per year) and continues to increase. The current trend of the state absorbing the cost of care for our elderly citizens must be reversed. Just as we must ensure that good quality care is given, steps need to be taken to prevent the cost shifting of middle income individuals to the welfare roles. As I stated previously, long term care is expensive and can very quickly exhaust nest eggs that people have worked for all of their lives. However, we must set reasonable criteria for admissions to nursing home facilities and provide a mechanism for our elderly citizen to be able to finance their own long term care needs without impoverishing their spouse. Resources must not be transferred to other relatives while expecting the government to absorb the cost of their long term care.

Long Term care insurance is being presented as the solution for the future. I agree that this is an important part of the

solution. However, private insurance is not free. No insurance company is going to provide the coverage to any person without the premiums being paid. The cost of long term care insurance is presently not included in the fringe benefit package of major employers. As American industry continues to be cost conscious as they compete in the international business arena, I don't expect them to accept this new cost willingly.

As we promote private insurance as part of the solution to the long term care financing challenge, steps need to be taken to ensure that quality insurance packages are being sold. Our elderly citizens are often sold products that are worthless. Government oversight definitely needs to be inplace to monitor the quality and performance of these plans.

The number of South Carolina's senior citizens is rapidly increasing. Medical and social problems of the elderly are a relatively new area for governmental planners. Traditional approaches to the problems of the elderly are proving too costly, inhumane, and ineffective. Reliable data on Alzheimer's and other debilitating diseases is simply not available to the health planners of South Carolina. These diagnoses are frequently cited on the medical records of patients found in nursing homes. While Alzheimer's has a significant impact on the institutionalization rate in South Carolina, I cannot identify any comprehensive study directed toward identifying alternatives to the routine placement of Alzheimer's victims in institutions.

Case management is the new term that's in vogue in health and human service programs. Federal studies continue to show that good medical case-management models reduce the cost of care and prevent unnecessary institutionalization.

The Community Long Term Care program administered by the HHSFC is one alternative program that has proven to be cost effective. Approximately 4,000 South Carolinians are maintained in their own community (homes) thereby reducing the need/demand for the much more costly institutional care. In addition to the reduced cost, even the critics of the program readily admit that the quality of life is better.

I've been discussing with you our traditional service package and identifying some of the changes that I feel must be made. The one point or factor that has been common throughout my discussion has been cost. How will we pay for the studies, collection of data and alternative service delivery systems that I am recommending?

In July of this year, the United States General Accounting Office (GAO) issued a report entitled, MEDICARE AND MEDICAID - STRONGER ENFORCEMENT OF NURSING HOME REQUIREMENTS NEEDED. In this report GAO analyzed records of nursing homes participating in Medicare and Medicaid in 1985. Forty-one percent (41%) of skilled nursing facilities and thirty-four percent (34%) of intermediate care facilities were out of compliance during three (3) consecutive inspections between 1981 and 1985. (South Carolina Facilities were not in the Survey.) I previously stated that the federal

government through the Medicaid program participates in the majority of the long term care cost. We cannot afford to ignore the developments in long term care as dictated by the federal government. Additionally, it is important to keep our own house in compliance with federal regulations.

Reimbursement/cost of long term care services is an issue that the institutes of medical study failed to address. The manner in which facilities are reimbursed is left up to the individual states. This is a very important issue because the reimbursement system can have a tremendous impact on the allocation of resources within a facility, and therefore, the type of care provided to patients. If delivering care to patients is to be the true objective of the long term care industry then the reimbursement system should reflect this objective. Currently, we basically have two (2) classifications of patients in South Carolina. It goes without saying that the needs of all those patients don't fit easily into the two (2) classifications available.

Case-mix or patient based reimbursement is being discussed. The emphasis here is to reimburse based on the patient needs instead of the certification/license of the facility.

Currently, the federal government is proposing a new catastrophic health program. However, this expansion of coverage does not address the most critical need of all; long term care. The expansion of services will not be absorbed by the federal medicare program, which will increase the burden on South Carolina Medicaid budget.

In closing I would like to state that the financing of long term care in South Carolina is currently a state problem. However, it is a problem that the State cannot solve alone as the demand for long term care increases into the year 2000. I want to emphasize that it is very important that a reimbursement system be fiscally responsible as well as equitable. All options to institutionalization must be evaluated with the objective to do what is best for our elderly population. We must all work together to design a system that is both affordable and that emphasizes quality of care and human dignity.

Thank you for allowing me to present these issues.

Mrs. Leslie Gilbert
S.C. Retired Educators Association
3612 Anwood Drive
Columbia, SC 29209

The South Carolina Retired Educators Association

421 Zimalcrest Drive Columbia, S.C. 29210 Phone 772-6553

The South Carolina Retired Educators Association is composed of approximately 5,000 retired members who have served the educational profession in a variety of roles and positions.

Its purpose is to promote a functional, unified organization devoted to the general welfare of retired educators. The Association is also committed to keeping members informed of special services and benefits that result from Federal, State, and local legislation. Members are encouraged to accept the responsibility to continue to engage in community involvement and service in the field of education and beyond.

A substantial segment of the current membership was engaged in active service during a time when the rate of compensation was minimal. In this respect, obtaining benefits for members is a necessary component of the South Carolina Retired Educators Association's legislative program; however, it is not the total focus of our efforts.

The legislative program for the current year continues the goals set forth in last year's proposals. Existing unmet needs become more acute as the cost of living increases. Compassionate concern for the aforementioned retirees must be translated into action.

Legislative Program

I. Compensation

A. Immediate Action

To provide an increase in the base retirement benefit for members of The South Carolina Retirement System who retired prior to July 1, 1972, the increase to commence with the July 1, 1988 monthly benefit. The increase is to be an amount equal to one dollar for each year of service and one dollar for each full year that the member has received benefits under the system. This base increase does not affect cost of living benefit adjustments or earning ceilings provided by law.

B. When Funds are Available

To provide an increase in the base retirement benefits for members of the S. C. Retirement System who retired prior to July 1, 1987, the increase to commence with the July 1, 1988 monthly benefit. The increase is to be an amount equal to one dollar for each year of service and one dollar for each full year that the member has received benefits under the retirement system. This base increase does not affect the cost of living benefit adjustments or earning ceilings provided by law.

II. Homestead Exemption

The request for increase in homestead exemption for elderly homeowners from $20,000 to $30,000 is continued.

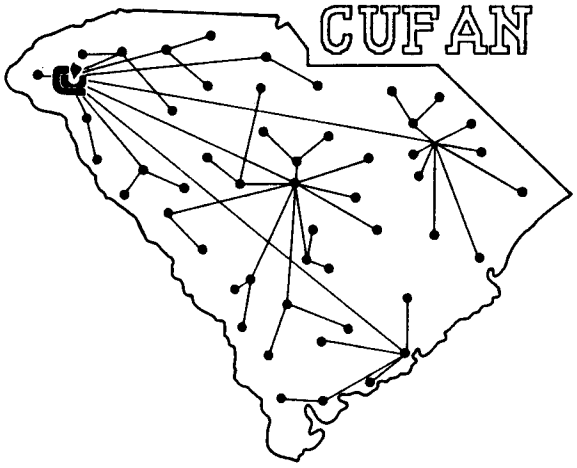
III. Critical Needs of the Elderly

The proposal of the South Carolina Commission on Aging relative to the critical needs of the elderly is supported again this year of the SCREA.

Dr. Emily Wiggins
Clemson University
240 Plant & Animal Sciences Bldg.
Clemson, SC 29631

WHAT IS CUFAN?

Clemson University Forestry and Agricultural Network is a computer-based system designed to provide you with information you need or want. CUFAN includes several information bases that you may query, a communications network for accessing the information bases, and electronic mail. A variety of information is provided from public, private and university sources.



WHO WILL BENEFIT FROM CUFAN?

Every citizen of South Carolina can benefit from CUFAN because of the variety of information that is available. Information on food, clothing and shelter is of interest to each of us. Students, teachers, public officials, administrators, housewives, home owners and others are able to use information on a variety of topics. Agricultural producers, businesses and financial institutions will find CUFAN information of particular interest. Other specialty groups will benefit from the information bases oriented to their particular area of interest.

WHAT WILL CUFAN MEAN TO YOU?

You will make better decisions when using CUFAN. Whether you use a weather forecast, nutrition information, news, plant culture or treatment recommendations, the information you use to make decisions will be up-to-date, accurate and state-of-the-art. You will be able to communicate electronically by E-Mail with others on the network. CUFAN will provide new windows into the world for you.

We live in an information age. We compete with nature, competitive businesses, our peers and ourselves for the good life. John Naisbitt has written that "The competitor with the most and best information stands to reap the most benefit from the competition." CUFAN is designed to provide you with the best information available in many areas of knowledge.

WELCOME TO CUFAN
CLEMSON UNIVERSITY FORESTRY AND AGRICULTURAL NETWORK
<1> WEATHER
<2> ECONOMICS
<3> PLANTS
<4> ANIMALS
<5> ENGINEERING
<6> FOOD
<7> HOME, HEALTH, FAMILY AND YOUTH
<8> COMMUNITY DEVELOPMENT
<9> MARINE
<0> NOTES, CALENDARS AND NEWS

Press the EXIT key(s) to return to the $ prompt(F1-. or PF1-.
Choice

WHAT WILL YOU NEED TO USE CUFAN?

You will need a personal computer, a modem and a communications program to access

CUFAN. IBM PC or Apple computers or clones work well in CUFAN. The modem allows your computer to be connected to the telephone and communicate with CUFAN. The communications program should be VT100 compatible. ProComm, Smarterm and Crosstalk work well with IBM; Apple Access II works well with Apple computers. Of course you may use the same computer for other activities as well as communicating with CUFAN.

WHAT WILL CUFAN COST YOU?

Use of the communications system of CUFAN will cost you $0.15 per connect minute. In addition, access of CUFAN information and E-Mail will incur a small charge for use of the host computer at Clemson on an as-used basis. The computer charge will usually be less than 10 percent of the communications cost. You will be billed monthly.

HOW CAN YOU PARTICIPATE?

After you sign a contract with CUFAN, a username and password will be assigned and a copy of the completed contract and complete instructions for use of the system will be mailed to you. You may obtain a blank contract by contacting the Clemson University Extension Office in your county. An extension agent will also be glad to provide you with a demonstration of CUFAN. If you live outside South Carolina, please telephone (803) 656-5080 and request a contract.

County Extension Offices

County	Telephone
Abbeville	459-4106
Aiken	649-6671
Allendale	584-4207
Anderson	226-1581
Bamberg	245-2661
Barnwell	259-7141
Beaufort	525-7118
Berkeley	761-8499
Calhoun	874-2354
Charleston	722-5940
Cherokee	489-3141
Chester	385-6181
Chesterfield	623-2134
Clarendon	435-8429
Colleton	549-2596
Darlington	393-0484
Dillon	774-8218
Dorchester	563-3441
Edgefield	637-3161
Fairfield	635-4722
Florence	662-8719
Georgetown	546-4481
Greenville	232-4431
Greenwood	229-6681
Hampton	943-3621
Horry	248-2267
Jasper	726-3470
Kershaw	432-9071
Lancaster	283-3302
Laurens	984-2514
Lee	484-5416
Lexington	359-4265
McCormick	465-2112
Marion	423-0891
Marlboro	479-6851
Newberry	276-1091
Oconee	638-5889
Orangeburg	534-6280
Pickens	868-2810
Richland	256-1678
Saluda	445-8117
Spartanburg	582-6779
Sumter	773-5561
Union	427-6259
Williamsburg	354-6106
York	684-9919

ADULT DEPENDENT CARE MENU

- DEMOGRAPHICS
- LIVING ARRANGEMENTS
  - RETIREMENT CENTERS
    - DEFINITION
    - LIST
  - LISCENSED COMMUNITY RESIDENTIAL CARE FACILITIES
    - DEFINITION
    - LIST
  - LISCENCED INTERMEDIATE CARE FACILITIES
    - DEFINITION
    - LIST
  - LISCENSED SKILLED NURSING CARE FACILITIES
    - DEFINITION
    - LIST
  - LISCENSED ADULT DAY CARE
    - DEFINITION
    - LIST
  - LISCENSED HOSPICES
    - DEFINITION
    - LIST
  - INTERMEDIATE CARE MENTAL RETARDATION
    - DEFINITION
    - LIST
- SERVICES
  - HOME HEALTH CARE AGENCIES
    - DEFINITION
    - LIST
  - STATE LIBRARY FOR THE BLIND AND PHYSICALLY HANDICAPPED
    - DESCRIPTION
    - ELIGIBILITY
- SERVICE PROVIDERS
  - COMMISSION ON AGING
    - DESCRIPTION OF SERVICES
    - LOCAL COUNCILS
  - COMMISSION ON DRUG AND ALCOHOL ABUSE
    - DESCRIPTION OF SERVICES
    - COUNTY OFFICES
  - COMMISSION FOR THE BLIND
  - DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
    - DESCRIPTION OF SERVICES
    - COUNTY OFFICES
  - DEPARTMENT OF MENTAL HEALTH
    - DESCRIPTION OF SERVICES
    - COUNTY OFFICES
  - DEPARTMENT OF SOCIAL SERVICES
    - DESCRIPTION ON SERVICES
    - LOCAL OFFICES
  - DEVELOPMENTAL DISABILITIES COUNCIL

ENERGY ASSISTANCE OFFICES
DESCRIPTION OF SERVICS
OFFICES
FAMILY SERVICE ASSOCIATION
DESCRIPTION OF SERVICES
OFFICES
SERVICE PROVIDERS CONTINUED
NURSING HOME OMBUDSMAN
RED CROSS
DESCRIPTION
OFFICES
SALVATION ARMY
DESCRIPTION OF SERVICES
OFFICES
SUNBELT HUMAN ADVANCEMENT RESOURCES
VOCATIONAL REHABILITATION
DESCRIPTION OF SERVICES
AREA OFFICES
ASOCIATIONS AND ORGANIZATIONS
EDUCATION
ELDERHOSTELS
SENIOR CITIZEN WEEK AT CLEMSON UNIVERSITY
SUMMER SCHOOL AT WINTHROP
LEGISLATION
JOINT LEGISLATIVE COMMITTEE ON AGING
SUMMARY OF LEGISLATURE AFFECTING THE ELDERLY
RECREATION
OTHERS
PROGRAM ASSISTANCE LINE (PAL)
THE SOUTH CAROLINA HANDICAPPED SERVICES INFORMATION SYSTEM
SOUTH CAROLINA GERONTOLOGY CENTER AT USC
NATIONAL EYE CARE PROJECT
SUPPORT GROUP NETWORK
VOLUNTEER COORDINATION

Rep. Blackwell - Are you going to list the number of beds available or give us also an inventory which ones might have vacanies?

Wiggins - Well since we are just going to update monthly, the information would not remain accurate. Anything that is apt to change daily like that then probably we could not do that. But the number of beds will give people some idea of the size of the institution.

Rep. Blackwell - Thank you.

Rep. Waldrop - Yes ma'am, Ms. Barron would like to make a comment.

Ms. Barron - On the back table we have a list of legislation pending in the 1988 session which we provided for Ms. Wiggins and she has really worked hard on getting this system up and running.

CLEMSON UNIVERSITY FORESTRY AND AGRICULTURAL NETWORK
APPLICATION FOR USERNAME

I, the undersigned, request an account and username for the purpose of accessing the CUFAN informatic base, electronic mail and communications network. With permission, I may also use other facilities within CUFAN. My application is subject to the following terms and conditions:

1. I agree to hold Clemson University harmless from liability arising from my use of CUFAN information or equipment.

2. I understand that the University's action in making CUFAN available is in the nature of a public service or is deemed to inure to the benefit of the University.

3. The term of this agreement is 1 July 1987 through 30 June 1988.

4. The rates and prices charged for use of CUFAN are designed to cover direct costs to the Division of Agriculture and Natural Resources. These rates are:

Communications Network	$0.15 per connect minute
VAX 8600 CPU	$6.00 per minute
Input/Output	$0.60 per 1000 records
Disk Storage	$5.30 per megabyte per month

If I use CUFAN during a calendar month, a $10.00 minimum charge will be incurred. Clemson University may charge me $10.00 if I request that my password be reset. Clemson University shall be the final authority on the validity and accounting information upon which charges are based.

5. Payment for services provided will be made monthly upon submission by Clemson University of a statement billing for services rendered in accordance with the rates set forth above. Clemson University may elect to terminate CUFAN services and/or charge a penalty of up to 1 1/2 percent per month on the unpaid balance if payment is not received within 30 days of receipt of the invoice.

6. Clemson University will not be considered in default with respect to any obligation of this agreement if prevented from fulfilling such obligation by reason of machine failures, system failures or other causes beyond its control, nor for delays caused by heavy demands on CUFAN by Division of Agriculture and Natural Resources staff. Clemson University will not be responsible for making backup copies of data files.

7. I may terminate this agreement at the end of any month by giving Clemson University at least 10 days advance written notice. If I do so, I will be responsible for removing any of my data from CUFAN before the termination date.

8. All operational considerations will be under complete control of Clemson University and will not be dependent upon my notification, approval or concurrence. I will adhere to all operational policies and procedures defined by Clemson University or any other consideration necessary for the overall successful operation of CUFAN.

9. After acceptance by Clemson University of this application, a copy will be mailed to me with an assigned account number (which will be my initial password), username and a user's guide.

CUFAN
115 McAdams Hall
Clemson University
Clemson, SC 29634
803-656-5080

Signature:_____ Date_____
Name:_____
Address:_____
City, State, Zip_____
Phone:_____

For CUFAN use only:
Account Number: _____ Username: _____

South Carolina Department of Mental Health
An Equal Opportunity Employer
P.O. Box 485 / 2414 Bull Street / Columbia, South Carolina 29202
Information (803) 734-7783

Joseph J. Bevilacqua, Ph.D. / State Commissioner
(803) 734-7780

REMARKS
JOINT LEGISLATIVE COMMITTEE ON AGING
PUBLIC HEARING, OCTOBER 7, 1987

The South Carolina Department of Mental Health is engaged in a dynamic planning process in order to systematically address the development and implementation of an array of mental health services for South Carolinians whose needs are diverse and complex. Our elderly citizens are especially vulnerable to stress and mental health problems because of predictable, yet significant, changes in their health, economic status, mobility, the constellation of their families and friends, living environment and lifestyle, etc. The chronic dilemna of institution based versus community based services is magnified for this group of people.

The Department of Mental Health currently operates 1126 beds for elderly people who need some level of supervised, supportive or nursing care. The Dowdy-Gardner Nursing Care Center operates a total of 518 beds for patients who need skilled or intermediate care but who have a primary diagnosis of some form of mental illness including the dementias. Tucker Center operates 608 intermediate and skilled nursing care beds for individuals who have no diagnosable mental illness. In addition, Crafts-Farrow Psychiatric Hospital has a current census of about 600. These patients represent a mixture of primary diagnoses and disabilities including mental retardation, mental illness, organic disorders, etc., requiring care ranging from psychiatric rehabilitation to domicillary care to nursing care. As long as legislation permits the commitment of people who are physically infirm or have illnesses and disabilities other than mentally illness there is little incentive to establish adequateappropriate care in the community.

The Department of Mental Health has become a major provider of institutional long-term care for people experiencing a remarkable mixture of illnesses and disabilities. The consequence is that services for the mentally ill are compromised because resources which should go for their care and treatment in the community are required to support institution based services which demand diverse treatment technologies. The private sector could provide cost effective care for many of these elderly if the provisions of the State Medical Assistance Plan were expanded. Patients inappropriately placed in Department of Mental Health beds do not qualify for Title XIX reimbursement, whereas under an expanded Plan, this care could be provided by the private sector.

RECOMMENDATIONS:

1. Comprehensive community based care for our older citizens requires the collaboration of several agencies and local interagency team work among service providers. The Long Term Care Council is vital in providing the necessary State level leadership to bring about such collaboration and needs continued legislative support and sanction which you have so generously given.

2. Legislation is recommended which would permit facilities such as local hospitals and nursing homes to retain jurisdiction or responsibility for fifteen to thirty days for elderly clients who, as inpatients, are committed to Department of Mental Health psychiatric hospitals from those facilities. Physically ill patients could be properly returned to these facilities as soon as they were medically able to travel.Elderly individuals who have psychotic symptoms because of medication reactions, toxicity or as a manifestation of a physical illness or an organic brain disease could be evaluated, stabilized and returned with a prescriptive set of recommendations for continued treatment.

3. Expansion of the State Medical Assistance Plan to include optional coverage for medically needy aged, blind and disabled would result in significantly more Federal funding support of nursing home beds. This would permit the transfer of many nursing care clients currently served by the Department's inpatient programs to private sector care and expand the availability of that care to clients who might otherwise be committed to us.

4. Continued and expanded legislative support to agencies to increase the State's capacity to provide home based care, support and intervention is urgently recommended. Such care for the elderly needs to include health services, home maker services, transportation, nutrition, mental health services, social support and assistance to maintain one's residence. our elderly citizens can maintain their health and well being longer if the State is committed to helping them live in a normal environment as long as possible. Conversely, Department of Mental Health institutional care to meet the medical and nursing care needs of physically ill elderly is the most expensive option for the State to exercise.

5. Pending legislation regarding long term care insurance coverage (H. 2673 and S. 603) needs passage and regulations emanating from that legislation through the Insurance Commission need to include coverage of Alzheimers' Disease and other dementias.

This concludes our recommendations. The work of this committee is most appreciated. The Department of Mental Health is committed to working with you and our fellow agencies to develop cost effective systems of care that improve the opportunities for our elderly citizens to live healthy productive lives.

S.C. Senior Citizens Sports Classi
326 Townes Rd.
Columbia, SC 29210

SENIOR SPORTS CLASSIC

May 15 - 16, 1987

FRANCIS MARION COLLEGE
Florence, South Carolina

is sponsored by

South Carolina Recreation
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South Carolina
Commission on Aging

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AARP
South Carolina Tennis Association
Womens International Bowling Congress
American Bowling Congress
South Carolina Federation of Older
Americans

SANCTIONED BY:

The U.S. National Senior Olympics

CARL HUST

Rep. Waldrop - Before you put on the 2nd hat. I'm sure Mr. Blackwell would like to discuss this. We no longer have these little funds that I believe you called "contribution section". We are going to have to go through PRT for these funds if it would be possible to do so. So I think you should make that effort.

Rep. Blackwell - Carl, we cut out contribution. I was one of those that wanted to see it cut out because I don't think that it belonged in a state budget. It's not a responsible way to appropriate money.

Hust - I can appreciate this. It's about time. I have been in state government for 30 years. I can appreciate some of the avenues in which that money was directed.

Rep. Waldrop - For the record, let it stand that if this Committee so desires to do so in our next meeting, November 5th, we will take this into consideration.

Rep. Blackwell - But you go ahead and make some preliminaries at PRT, too.

Hust - I have already appeared before the Commission on Aging and made an overview in terms of supporting this program.

Elizabeth Winkfield
c/o Suzanne S. Crooke
1800 Main St., Suite 3-C
Columbia, SC 29063

JOINT LEGISLATIVE COMMITTEE ON AGING - PUBLIC HEARING

Wednesday, October 7, 1987

My name is Elizabeth Winkfield and I am a Foster Grandparent Volunteer with the Foster Grandparent Program which is sponsored by the Council on Aging of the Midlands. I serve as a Foster Grandparent Volunteer at the South Carolina Department of Youth Services, Willow Lane Campus in Zeta Cottage, which is the maximum security unit for the teenagers at Willow Lane.

The Foster Grandparent Program is a National Program which began 22 years ago across the United States. Foster Grandparents are individuals who are 60 and older and live on limited incomes. Foster Grandparents volunteer 20 hours per week with children that have special or exceptional needs. Such as abused children, troubled teenagers, mentally and physically handicapped youngsters, sick children and the list goes on. We receive a small stipend of $2.20 an hour for our volunteer week. For many of us this helps us to be able to volunteer. Other benefits we receive include a physical each year; volunteer insurance to cover us while driving to and from our volunteer stations, as well as accident insurance while volunteering; assistance with transportation, if needed; a nutritious meal at our volunteer stations and annual and sick leave and holidays. The primary benefit we receive is giving and receiving love from the children we work with each day.

As I mentioned, the Foster Grandparent Program is sponsored by the Council on Aging of the Midlands. We receive most of our funding from ACTION, the Federal Domestic Volunteer Agency. We also depend on support from the community and donations from individuals.

Here in Columbia, our program serves both Richland and Lexington counties. As of today we have 66 active Foster Grandparent Volunteers. The Foster Grandparents volunteer in 11 volunteer stations. These include South Carolina Department of Youth Services, Richland Memorial Hospital, Wil Lou Gray Opportunity School, Midlands Center, Greenview Elementary School, Two Head Start Centers and four others. The Program is 20 years old here in Columbia. We are one of 250 Foster Grandparent Programs across the United States, Puerto Rico, the Virgin Islands and the District of Columbia. There are two other programs in South Carolina - Charleston and Aiken and we are the largest, here in Columbia.

Last year the Foster Grandparents in Columbia gave over 60,000 hours of volunteer service to over 700 children with special or exceptional needs. That is a lot of hours of love and attention given to the children in the Midlands area.

I have been a Foster Grandparent at the Department of Youth Services for 3 years. I am a Foster Grandparent because I love working with children and people of all ages, too. I feel my presence at the Zeta Cottage helps the children who are so troubled. I spend many hours just listening to the children and being there to give advice when they ask for it. I feel very fortunate that my own children have not had any serious problems and I want to share my love and talents and hopefully help someone else's children who need someone speical in their lives. I work with children who are elementary school age and up to 17 years old. The children have so many different problems and some days it takes a lot of patience to work with them but every morning, Monday through Friday I look forward to being with the children and sharing of myself with them. I work in a classroom in Zeta Cottage with Pam Faulkenberry, the classroom teacher. In addition to giving a lot of love, attention and advice to the children I help them with their classroom work.

I appreicate the opportunity to share with you what I do as a Foster Grandparent Volunteer and welcome you to come visit me at South Carolina Department of Youth Services. The Foster Grandparents are making a difference in the lives of many children in our community, state and the nation.

Rep. Blackwell - **You are an inspiration to us. It's good to hear this kind of report.**

Rep. Waldrop - **I think Rep. Blackwell made a statement that the whole committee condones.**

Clem Cannon
191 Carlyle Circle
Columbia, SC 292(

OCTOBER 7, 1987

MY PERSONAL EXPERIENCE AND VIEWS AS THE SPOUSE OF AN ALZHEIMER'S PATIENT

by Clem Cannon

My wife was diagnosed as having Alzheimer's Disease in 1984. All of our goals and aspirations had to take a 180-degree turn after learning about this illness. The anguish, pain, frustrations and insecurity were almost intolerable. Relying on a religious background gave me strength to cope with this monster. Trying to work and give custodial care is a ticket to one's own destination. Seeking help offered the only alternative. I found day care centers to be a life saver; it gave temporary peace of mind, a time for ~~from~~ mental and physical rest. Staff and helpers of these centers are to be commended for their dedication, caring and love. Many family caregivers feel that the door has been opened; it is a good and much needed start. We are in hope that the program can be expanded to include weekends and vacations. Caregiving to dementia patients is a demanding and privacy-robbing twenty-four-hour day task. We continue to believe that these stressful problems can be addressed.

Support group sponsored by ADRDA have given me added courage and strength to cope with this terrible disease. Without these community services I dread to think what effect the emotional and physical strain would have. This devastating disease has been called "the disease of the century" and it also has been referred to as a "democratic disease," for it has no preference for race, occupation, socioeconomic status or sex. Alzheimer's Disease had a profound effect on all all areas of our life--interfering with work, social activities, plans for future, and the [illegible]

Emotional support and assistance with help from family, friends and communi[illegible] agencies are essential. The disease has a predictable regressive course, which will require an increasing amount of care and eventually institutionalization. Knowing this about the future causes a great deal of economic insecurity. If energies and resources can be expanded to give added services to the existing community programs it would help greatly to ease the extraordinary burden.

Thank you for listening and caring.

Rep. Waldrop - Thank you, sir. I appreciate your remarks. I'm sure it came straight from the heart.

Joy Beck, Exec. Dir.
Pickens Co. Seniors Unlimited
P.O. 6
Liberty, SC 29657

Joint Legislative Study
Committee on Aging
Testimony
October 7, 1987

Joy Beck
Executive Director
Pickens County Seniors Unlimited
P. O. Box 6
Liberty, S. C. 29657
Telephone (803) 843-2275

Mr. Chairman and Members of the Joint Legislative Study Committee on Aging:

My testimony today is for the awareness of the need of public transportation for the general public and for the elderly.

The Councils on Aging and the State are able to work together in that Councils on Aging are eligible to be covered under the State's Reserve Fund. The State Reserve Fund provides coverage for $500,000.00 per occurrence and the State cannot be liable for more than $500,000.00. By being on the State Reserve Fund, our agency has been able to spend less on insurance coverage than we would have, if we have used a private vendor. An agency is eligible for the State Reserve System, if they receive either Federal or State monies for transportation services.

I would like to express my appreciation to Senator Isadore Lourie for past legislation that protects the State from being liable for more than $500,000.00. Also we are thankful for Senator Lourie's impact in earmarking one-fourth of one cent of the three cents gasoline tax increase last session for the procurement of vehicles and the enhancement of public transportation. The enhancement of the public transportation systems includes retrofitting current vehicles and up-grading the present system. The funds earmarked for enhancement of public transportation will total five to six million dollars.

There is a need for public transportation not only for the rural areas, but statewide.

Presently in my county of Pickens, our Agency provides transportation county-wide for the elderly to the Senior Centers, for essential shopping, to physicians, and medical transportation for all medicaid recipients.

We would provide transportation to other places for our seniors, but we are not able to, due to a lack of adequate funding for transportation. Some examples of needs we are not meeting are taking our Seniors to visit their loved ones who are in nursing homes, shopping at local shopping centers and the general running of errands. Just because people have lost the ability to drive due to physical impairments, it does not necessarily mean that they would prefer to stay home.

In my county of Pickens, the Rotary Club International has become very concerned about the lack of adequate transportation, especially for the elderly. Therefore, the Rotary Clubs in both Pickens and Oconee Counties have started a volunteer initiative with our agency. This effort with the Rotary Clubs developed because of concerns expressed by the elderly in regard to the lack of public transportation. The Rotary began by volunteering to print the 1987 Directory of Services available for the Elderly in Pickens and Oconee Counties. The directory was produced by selling advertisements to local businesses by college students from Central Wesleyan College. All directories were given away at no charge to the elderly and businesses throughout both counties. The funds remaining after the publication of the directory were given to Seniors Unlimited as seed money to enhance our present transportation program for the elderly.

More and more elderly are migrating into our State of South Carolina. One of their chief questions before they decide to move here involves asking if there is a public transportation system available so they can easily go from one place to another. Therefore, let me conclude by saying we should have a transportation system in place, not only to attract new retirees to our State, but even more importantly, to provide for our current elderly population across the State.

Rep. Blackwell - You are the Executive Director for seniors in Pickens County.

Beck - Yes.

Rep. Blackwell - Do you have a County Council on Aging, otherwise?

Beck - We are the Concil on Aging.

Rep. Blackwell - Were you here this morning when Rep. Kirsh testified?

Beck - Yes sir.

Rep. Blackwell - You heard his proposal. How do you stand on that? Would you like to see Pickens County made a separate Area Agency on Aging or taken out of the Appalachian Council of Governments?

Beck - No sir. We get strong support from the Appalachian Council of Governments.

Rep. Blackwell - You don't begrudge the money that's spent there.

Beck - No, as a matter of fact, Appalachian Council of Governments helped me as far as knowing that transportation was one of the needs that the elderly ask about when they come into our county. We work closely with them.

Rep. Waldrop - Thank you Miss Beck, any questions?

Sen. Lourie - How many vans do you have Joy?

Beck - At present, we have six and we are coordinating closely with the Department of Social Services with Medicaid recipients to coordinate schedules for persons that need to go to physicians and hospitals.

Sen. Lourie - Is there any other mode of transportation available to the citizens?

Beck - No sir.

Sen. Lourie - Any type of bus service?

Beck - No sir. There's been talk of Greenville Transit wanting to come through our county with a service but a lot of our seniors have expressed that they're afraid that they will just pick them up and take them to Greenville. They want to be able to shop in their own county.

Sue Summer, Director
2221 Devine St.
Columbia, SC 29205

Health Care: A Priority Concern for Older Women

The South Carolina Commission on Women would first like to express its appreciation for the opportunity to speak before this distinguished committee. We are grateful for the ability and concern with which you are facing the challenge of meeting the needs of South Carolina's older population.

By means of introduction, I am Sue Summer, director of the Commission since May. I am a former English teacher from Newberry, so if I tend to assign homework as I go, I hope you'll forgive me. Old habits are hard to break.

I am sure you are aware from the demographics of aging that we women are not just getting better--we are, indeed, getting older, as well...as Representative Waldrop might testify. Just last week-end, he attended the 90th anniversary tea of my mother-in-law's UDC chapter, and I'm sure he would tell you that women do comprise the great majority of South Carolina's older citizens...

The Commission on Women is concerned about many of the issues that impact on the lives of older South Carolinians: nursing home regulations, day care for the elderly, safe housing, the extreme poverty of older women, and the problems of displaced homemakers--those who, because of death or divorce, will first consider employment at a time when others of the same age are considering retirement. The Commission would like to express its concern about these issues, but I would also today like to focus tightly on an issue the Commission has identified as a priority concern of older women--health care.

On the State level, the Commission on Women would like to bring three recommendations to your attention:

1) The Commission would recommend that any longitudinal study of aging should include women in numbers proportionate to their numbers in the general population. There are more older women than older men; women form the great majority of our elder population. Yet, in the past, researchers often studied men and assumed the data could be extrapolated. Not true. (For example, we know that older men tend to suffer from one disease, while older women tend to suffer from multiple, chronic diseases.) Too, past researchers often focused on the health issues of younger women still in their childbearing years--and so it is that the older woman has, in essence, fallen through the cracks in research on

health concerns. Anything you might be able to do to make certain that women are better represented in future studies would be greatly appreciated.

2) The Commission would recommend more discharge planning and home health care services for older patients. There is, now more than ever, a need for alternatives to in-hospital health care--because people are leaving the hospital more quickly than ever before. After an operation that might once have required a six-day hospital stay, many patients are now being discharged after three days. Often, elderly patients who live alone need follow-up care that could be provided through home health care services.

3) The Commission would recommend that preventive health care services be extended to the elderly and be emphasized to a greater degree--perhaps through projects such as the pilot program in South Santee, which was the subject of an ETV program entitled, "Ain't Tired Yet". In some programs, older, healthy volunteers receive lay training to help them recognize health problems which might require medical services--and then these volunteers are sent to visit in the homes of those who are older and frail. Not only are frail elderly encouraged to receive preventive health care, but volunteers, who are retired, also benefit from the program as they find renewed purpose in their lives. Community approaches to preventive health care might also include an effort to identify neighborhood or church leaders so that these leaders might contact people and agencies in the medical system about providing services to those in need. This is a low-cost, effective way to extend medical services.

Finally, I would like to bring to your attention a problem in the Federal system that impacts on the State system and on individuals in this State. I realize that you cannot solve this problem, but I also know that you can help in bringing it to the attention of those who can.

Often, I--as I'm sure you must-- receive telephone calls or letters about heartbreaking situations. A social worker in Orangeburg recently alerted me to one such situation which affects women she calls "Black Widows". That is her term for women who have been receiving SSI disability--who have been certified as unable to work--but who, at age 60, are required by federal law to apply for social security widow's benefits instead of continued SSI disability benefits. When these social security benefits exceed $360 a month, then the "Black Widow" is no longer eligible to receive Medicaid--but, until she turns 65, she is not eligible for Medicare, either.

Catch 22...Just as a chronically ill woman reaches the

age when her health needs are critical--age 60--she loses access to the health care delivery system.

One Orangeburg County woman with severe, debilitating asthma--even as we speak--has a drawer full of bills from her doctor, from the hospital emergency room, from the pharmacist...And if she doesn't pay, how can she go back for more help when needs it? In four years, she will be eligible for Medicare, but meanwhile, she faces hard choices: Does she pay the doctor or the landlord? Does she buy fuel or medicine? Does she breathe--or eat?

What about medical care for indigents? Why can that program not offer this woman help? Indigent care covers only in-hospital care, and most often this asthmatic woman has been treated in the emergency room and released.

In our medical services delivery system, there is a five-year hole that needs to be patched. I realize that you gentlemen did not cause the rip--nor do you own the needle and thread needed to patch it. But perhaps if you call for the patch to be sewn, then those who can sew, will. I ask that you use your strong voices to speak for the weak and powerless and the poor.

So much for the homework assignment...you all get A's for your hard work here today. I appreciate your attention, your concern, your help--and your indulgence. If ever I can be of any assistance to you, please don't hesitate to call. I look forward to hearing from you.

Rep. Blackwell - **Why were these widows not eligible for disability payments on their husbands' records? As a disabled widow over 50 becomes eligible for payments after 24 months of payments. Does she not qualify for Medicare?**

Summer - **She is receiving SSI on her own from being disabled.**

Rep. Blackwell - **Your statement, I don't mean to quarrel and I guess I am, but your statement implies that she becomes eligible as a widow at age 60. If that be true if she is disable enough to be disabled for social security, she should have qualified as a disabled widow as early as age 50.**

Summer - **I'll go back and check on that but this is the information I recieved.**

Rep. Blackwell - **You ask your Social Security people, whether or not a person can become entitled as a disabled widow at age 50. I worked with them for 25 years and but I may be mistaken.**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to:

10/14/87

Strom Thurmond
Federal Building
Second Floor
1835 Assembly Street
PO Box 2568
Columbia SC 29202

October 9, 1987

Ms. Sue Simmons
S.C. Commission on Women
2221 Devine St. Ste. 408
Columbia SC 29205

Dear Ms. Simmons:

I am writing in response to your inquiry of October 8 regarding the woman whose Supplementary Security Income check, and therefore her Medicaid coverage, ended when she became entitled to Social Security widows benefits at age 60, her widows benefit being based on age rather than her being disabled. Your question was whether indeed this is possible, and if so, how it might happen.

The facts of the case you cited include the following:

1. The worker was last employed in 1958.
2. The worker became disabled in July 1958, and the family drew disability benefits until the worker died in September, 1973. Thereafter the family continued drawing survivor benefits.
3. The widow lost her entitlement to benefits as surviving young mother effective September 1976 because her youngest child turned 18 that month, and she no longer had a dependent minor child in her care.
4. The widow became 60 years of age in October, 1985
5. She became entitled to SSI payments effective June, 1982.
6. She became entitled to aged widows benefits effective October, 1985.
7. Effective November 1985 her total non-SSI income was $349.02.
8. Effective November 1985 the income limit for SSI entitlement was $334.

Our records show that the widow did not meet the medical standards for disabled widows benefits prior to August 31,1983, the end of the period during which by law she would have been eligible for such a benefit. This period ends 7 years after the widow's benefit as a young mother terminates. In this regard let me point out two things: first, that the medical standards for disabled widows benefits are different (more stringent) than those for SSI disability benefits; and second, that we do not have the file in question on hand so cannot describe the basis for that decision.

Supplemental Security Income regulations require that the recipient of SSI payments must apply for any other kind of benefit to which he/she may become eligible. Therefore this claimant was required to file for aged widows benefits at age 60. Had she refused to do so she would have lost her SSI benefit for not pursuing this other benefit. Because her combined income exceeded the SSI limit, the SSI check was stopped. Medicaid terminated along with SSI, because the State's Medicaid eligibility standards are based on SSI eligibility. Continuing Medicaid coverage after SSI terminated would have to have been based on the State's independent standards. As you pointed out, the claimant did not meet these standards.

If the claimant's widows benefit had been based on disability, she could have been entitled to Medicare coverage after drawing disability benefits for two years. As it is, she will not be eligible for Medicare coverage until age 65.

This scenario is accurate according to the provisions of current law. This particular claimant is unfortunately disadvantaged by the interworking of the provisions in that she has no medical coverage for several more years.

If you need clarification of any of this information, or additional data, please feel free to recontact me. Some pamphlets are enclosed dealing with these issues.

Sincerely,

Joseph W. Murray
Public Affairs Officer

Ted Willis
SC Retired Educators Ass
421 Zimalcrest Dr.
Columbia, SC 29210

TED WILLIS

I'd just like to make a comment if I may. I'm Mr. Ted Willis, Chairman of South Carolina Retired Educators Association, I'd like to thank this committee and the staff for the attentiveness and patience that you have exhibited here today. I'd also like to thank Mr. Blackwell, Waldrop and Mr. Harris for sponsoring and getting passed House Bill 2673 and I'm sure we can depend on Sen. Lourie to continue his fine work. We want to get this passed this session through the Senate. Mrs. Gilbert spoke very well to our program but I'd like to make one observation - So many of the people that have testified here today have not been employees who will benefit or were doing it because they were paid to. I was inspired by many of our speakers because they have done this out of compassion for our elderly citizens. We in the education association retired group are concerned about some 5,000 of our collegeus who retired prior to 1972 who can hardly exist on their retirement benefits and that's why it is of upmost importance that we get through the legislature this year the 1 + 1 legislation that would adjust retiree benefits for persons retiring before July 1, 1972. Thank you very much..

Sen. Lourie - When we took the break and I went down to Eastover to speak to the Senior Citizen group down there in the church, two issues which occured there and everywhere I go with senior citizens were: continuing escalating costs of drugs and matter of public transportation. As you know the oversight committee is getting ready to undertake its responsibilities with the new gasoline tax. Does our Committee have an up to date policy statement on public transportation, Keller? I know we dealt with the matter in years past.

Ms. Barron - No, we really don't.

Sen. Lourie - Do you think we should address some type of policy position to present to the Oversight Committee? I'm very anxious to see that 1/4 of one cent is allocated to public transportation toward the senior citizen groups as much as possible.

Rep. Waldrop - Sen. Lourie, would you like to make that in the formal motion today or wait for the November 5th meeting to do this after we analyze the testimony today.

Sen. Lourie - I think it is probably better to wait until November 5th, Mr. Chairman but I would just like it to be on the agenda.

Rep. Waldrop - Thank you Senator. For everyone that is still with us that testified today, everything will be taken into consideration and we will take the proper action. I'd like to state that there were some written statements submitted: Thomas Brown, Department of Health and Environmental Control issued a written statement which was submitted to our Committee; Dr. C. Julian Parrish, former member of the Committee on Aging, the S.C. Bar also did; Mr. Robert Kunes with Evans, Carter, and Kunes, attorneys at Law, Annette M. McKinney of Summerville and James Hollingsworth of Mt. Pleasant.

Once again Mr. Harris hopefully will be healthy before long and if any of you get a chance to call him or drop him a card, I'm sure he would have loved to have been here today. I'm honored to serve as Vice-Chairman of this Committee and to be able to Chair today. It's a good experience. But we will meet November 5th and once again we have open meetings and you are more than welcome at that time to come back.

South Carolina Department of Health and Environmental Control

Tom Brown, Director
Office of Program Mgt
DHEC
2600 Bull Street
Columbia, SC 29201

2600 Bull Street
Columbia, S.C. 29201

Commissioner
Michael D. Jarrett

September 24, 1987

The Honorable Patrick B. Harris
Joint Legislative Study Committee Aging
Blatt Building
Columbia, SC 29211

Dear Representative Harris:

In lieu of my making a formal presentation at the annual public hearing of the Joint Legislative Study Committee on Aging, I am submitting the attached update on several important activities which DHEC is conducting to improve health and long term care services for elderly South Carolinians. I request that this update be accepted as written testimony and be included in the record of the public hearing.

If I can be of assistance to the committee during your deliberations in the upcoming legislative session, please feel free to call on me.

Sincerely,

Thomas E. Brown, Jr., Director
Office of Program Management

gtd

Attachment

a:harris.txt

Presentation to the Joint Legislative Committee on Aging
October , 1987
Thomas E. Brown, Jr., Director
Office of Program Management
S. C. Department of Health and Environmental Control

Chairman Harris and members of the Committee, thank you for the opportunity to address the Study Committee. First, I would like to congratulate you and express my appreciation for the diligent and effective work of the Committee members during the 1987 Legislative Session. You achieved a number of successes including the funding of in-home supportive services for the frail elderly through bingo tax revenues. This new initiative will have a meaningful impact on the large amount of unmet need for these services among elderly South Carolinians.

For many years, the South Carolina Department of Health and Environmental Control (DHEC) has provided in-home skilled nursing and therapist services to homebound individuals. These services grew from the traditional public health visiting nurse to a certified Home Health service in 1969. Since that time, DHEC has expanded and improved its services to fill gaps in services and to meet additional service needs throughout the state. Two important new initiatives, which are supported by private foundation grant funds, are being implemented to improve further the health and long term care services for impaired, frail elderly persons.

DHEC and Richland Memorial Hospital (RMH) are jointly planning to participate in a demonstration project which will establish a new organizational approach and financing mechanism for health and long term care services for frail elderly persons. The project will replicate the On Lok program model, which is a capitated reimbursement system that provides HMO-like services, supported by a combination of Medicaid, Medicare, and client funding. The program includes service coordination by a multidisciplinary team, and provides for primary care, medical day care, community-based services, residential, hospital and nursing home care depending on the patient's needs. The administrative structure of the model relies on careful monitoring of clients, services, and costs to provide flexibility in adapting the program and to assure a sound financial base.

A feasibility study has been conducted by On Lok, RMH and DHEC staff to assess the capabilities of RMH and DHEC to implement a risk-based long term care program in Columbia. The report's findings were that the organizational strengths include a history of cooperative working agreements between RMH and DHEC, commitment of adequate resources to project development, and strong service and administrative staff.

DHEC has considerable experience with Home Health services and community-based long term care; RMH serves a sizable number of geriatric inpatients and is affiliated with the USC Medical School. Areas that need further development include: client recruitment, development of medical day care capacity, and cooperative agreements with other service

providers and other state agencies. With successful accomplishment of these activities, the report indicates that it will be feasible to implement a risk-based long term care program in Columbia.

Presently, DHEC and RMH staff and Boards of Directors are evaluating the report to determine a feasible financial plan for the effort. The final decision to either implement or not implement the project will be made by October 31st. If the project is implemented, it will serve 200-400 frail elderly persons from Columbia and the vicinity annually.

DHEC is assisting in the development of a second demonstration project in Charleston and Beaufort Counties. The Senior Support Services Project is designed to fill gaps in the availability of in-home supportive services for patients who are not eligible for Medicaid benefits and the Community Long Term Care program. The project has been operational for only a few months. Activities to date have included hiring staff, completing a market survey in both counties and accomplishing the administrative functions necessary to conduct the project. Project services, which are aimed toward elderly persons with slight, moderate and severe impairments, should begin in January 1988. The market survey identified significant need for in-home assistance with activities of daily living and instrumental activities of daily living among the non-CLTC population in both counties. A final decision regarding the service package, service pricing and service delivery approach will be made over the next few months.

Thank you again for the opportunity to address the Committee about these two demonstration initiatives. I look forward to working with the committee and hope to be able to report on the successful progress of our demonstration projects in the future.

a:present.txt

Dr. C. Julian Parrish
125 E. Marshall St.
Hempstead, L.I. N.Y. 11550

Joint Legislative Committee on Aging

State of South Carolina

PATRICK B. HARRIS
House of Representatives
Chairman

KELLER H. BARRON
Director of Research

SHERRI L. CRAFT
Research Assistant

212 BLATT BUILDING
P.O. BOX 11867
COLUMBIA, S.C. 29211
(803) 734-2995

October 5, 1987

#125 - E. Marshall St.
Hempstead, L.I. N.Y. 11550

To: Mr. Patrick B. Harris, Chairman
c/o Mrs. Keller H. Barron, Research Director
212 Blatt Building - P. O. Box 11867
Columbia, S.C. 29211

Greetings To The Joint Legislative Study Committee on Aging

For many valid reasons I cannot attend the Public Hearing on October 7th.

This does not mean however that I should refrain from being continiously concerned about one of the Major concerns in American life.

My desk is flooded with letters from a wide variety of unprecedented plans to provide insurance to Older Americans and some of the Entrepreneurs are merely newcomers in the business world in quest of the all powerful Dollar.

As a Citizen at large, my concerns are deep rooted in establishing and supporting programs from both the government and the private sector that can and or will provide retirement benefits, medication and clinic and Hospitilzation for the millions of Americans who require these aforementioned services.

The whole offerings of the government and the private sector have become a perilous problem of legalistic jargon that affects the physical and mental well being of the at large citizenry.

If the Study Committee will undertake to get clarity into the provision of contractual services and delete the one word that in my opinion is both Arbitrary and Capricious and that is the use of "Deductibles."

It has been my personal experience in the 1985 illness of my wife who required Hospitilization, Physical and Speech Therapy, a variety of prescriptions, a home attendant, equipment, dietary foods, and etc. We found that the Social Security Administration, Local Medical Providers, Medical Specialist, Subcontractors of Medical Needs and the Agency, Representatives of Agencies, were confused and almost at a total loss to explain the intricate formula of "Deductible."

To our honest way of analysis of the whole schismatic problem, is that No One wants to be the loser of money in the inflated charges for medical, hospital, and service charges.

This request for a fresh look into the formula of Deductibles is not a short range, quick gimmick, but a much needed reform on behalf of medical providers, sub-contractors of Goods and Services, and the Thousands of Needy Americans, who have now become Intra State Applicants for assistance to live in a very costly and confused technological society.

In conclusion, The Joint Legislative Study Committee, The Commission on Aging, the Associations, AARP, and the Executive Branches of Federal and State Governments, need to take a fresh look into the formula for Cost factors and Service charges, plus plain, clear language definitions of "Deductibles." This alone is another much needed Imperative.

Very best wishes,

C. Julian Parrish

C. Julian Parrish

Retired 1974 Director of Ethnic Research - New York State Civil Service Department of Albany, New York. 1966-1974.

1946-1966 Previous positions: Placement Interviewer, Job Developer, Placement Interviewer of Executive and Technological Employees in the Apparel Trades, Retraining Specialist for the Unemployed and Underemployed workers of various industries, Conversion factors relative to employment, and Occupational Analysis.

October 5, 1987

121 Glenshire Dr.
Columbia, SC 29203

The Honorable John Bradley, Chairman
Insurance Sub-Committee
Labor Commerce and Industory Committee
1063 Northbridge Dr.
Charleston, SC 29407

Dear Representative John Bradley

My desk is flooded with letters from a wide variety of unprecedented plans to provide insurance to Older Americans.

As a citizen at large, my concerns are deep rooted in establishing and supporting programs from both the government and the private sector that can and or will provide retirement benefits, medication, clinic and hospitalization for the millions of Americans who require these services.

The whole offerings of the government and the private sector have become a perilous problem of legalistic jargon that affects the physical and mental well being of the at large citizenry.

I am asking if you will undertake to get clarity into the provision of contractual services and delete the one word that in my opinion is both arbitrary and capricious and that is the use of the word, "Deductibles."

We had personal experience with "Deductibles" during the 1985 illness of my wife who required hospitalization, physical and speech therapy, a variety of prescriptions, a home attendant, equipment, dietary foods, and etc. We found that the Social Security Administration, local medical providers, medical specialists, subcontractors of medical needs and the agency, representatives of agencies, were confused and almost at a total loss to explain the intricate formula of "Deductibles."

In conclusion, I believe that a fresh look needs to be taken into the formula for cost factors and service charges, plus plain clear language definitions of "Deductibles."

My wife and I certainly will appreciate any attention and consideration which you can give to this matter

Very best wishes,

C. Julian Parrish

C. Julian Parrish

cc: Representative Clyde Dangerfield
Blatt Building

SOUTH CAROLINA BAR

1321 Bull Street/P.O. Box 11039
Columbia, South Carolina 29211-1039
Telephone (803) 799-6653

October 5, 1987

Eve Moredock Stacey
Public Service Director
SC Bar
1321 Bull St./P.O. 11039
Columbia, SC 29211-1039

Patrick B. Harris, Chairman
Joint Legislative Committee on Aging
Post Office Box 11867
Columbia, SC 29211

Re: Proposed Amendments to the
Death with Dignity Act

Dear Mr. Chairman:

As the Committee on Aging is aware, a great many problems or potential problems have been identified in the Death with Dignity Act. It was with these in mind that the Chairman of the South Carolina Bar's Probate, Estate Planning and Trust Section asked that an ad hoc group of lawyers, doctors and other interested persons get together and propose suggested corrective amendments to the Act.

In anticipation of your Committee's Public Hearing on October 7, I write to tell you that this ad hoc group has been hard at work. Chaired by Professor Elizabeth G. Patterson, professor of health law at the USC School of Law. the group included representation from diverse professional interests. In addition to Professor Patterson, membership included probate attorneys Marshall Allen, Morris Cox and James LeBlanc; medical ethicist Nora Bell; hospital defense attorney Preston Callison; State Ombudsman Frank Rogers; medical defense attorney Angela Henry; Don Saunders, M.D.; and Commission on Aging attorney Lawrence Solomon.

The report of that group has been submitted to the Bar, and is being studied by the Probate, Estate Planning and Trust Section, as well as by the other affected professional associations. A recommendation and official position of the South Carolina Bar are anticipated by the time of your Committee meeting November 5, 1987.

A great deal of work has been done by this group, and I want to bring it to the attention of the Committee on Aging. We regret that we do not have an official report for your Committee at this time, but hope that you will have adequate time to consider the report at your November meeting.

I look forward to providing the report of the South Carolina Bar on this important Act. Please do not hesitate to contact me if you have questions at this point.

Sincerely,

Eve Moredock Stacey

Eve Moredock Stacey
Public Services Director

cc: Professor Elizabeth G. Patterson
T. Emmet Walsh, President
South Carolina Bar
W. Steven Johnson, Chairman
Probate, Estate Planning and Trust Section

Robert M. Kunes, Attorney
Evans, Carter and Kunes
151 Meeting Street
P.O. Box 369
Charleston, SC 29402

EVANS, CARTER AND KUNES
ATTORNEYS AT LAW
151 MEETING STREET
P. O. BOX 369
CHARLESTON, SOUTH CAROLINA 29402

GEORGE C. EVANS
T. HEYWARD CARTER, JR.*
ROBERT M. KUNES*†

*CERTIFIED SPECIALIST IN TAXATION LAW
†CERTIFIED SPECIALIST IN ESTATE PLANNING AND PROBATE LAW

TELEPHONE 577-2300
AREA CODE 803

September 30, 1987

The Honorable Patrick B. Harris
Chairman
Joint Legislative Committee on Aging
P.O. Box 11867
Columbia, SC 29211

Dear Representative Harris:

Regrettably, I will be unable to attend the public hearing on Wednesday, October 7, 1987. However, I would like to write expressing my support for the proposed modifications submitted by the Committee of the Probate Section of the South Carolina Bar focussing upon the amendments to the Death With Dignity Act. Professor Patterson's committee has done an exemplary job of focussing upon some of the shortfalls that I, as a practitioner, noted with the legislation and I would like to go on record as strongly supporting the proposed amendments to the Death With Dignity Act.

With kind regards, I remain

Very truly yours,

Robert M. Kunes/pkm

Robert M. Kunes

RMK:pkm

cc: Professor Elizabeth G. Patterson
W. Steven Johnson, Esquire
W. E. Applegate, III, Esquire
Members of the Joint Legislative Committee on Aging

ANNETTE M MCKINNEY 418 CENTRAL A
418 CENTRAL AVE
SUMMERVILLE SC 29483 05PM

Western Union Mailg

Annette M. McKinney
418 Central Ave.
Summerville, SC 29483

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KELLER H BARRON, DIRECTOR OF RESEARCH
212 BLATT BLDG
COLUMBIA SC 29211

PLEASE READ AND PUT THE FOLLOWING ON RECORD IN THE JOINT LEGISLATIVE STUDY COMMITTE ON THE AGING ON WEDNESDAY OCTOBER 7TH IT IS WITH GRAVEST CONCERN THAT I AM IN OPPOSITION OF THE DEATH WITH DIGNITY ACT-LIVING WILL LEGISLATION THAT HAS PASSED I WOULD URGE ANYONE WHO IS CONSIDERING SIGNING THESE TO LOOK INTO CASES AROUND THE COUNTRY AND THE IMPLICATION OF GIVING SOMEONE ELSE CONTROL OF YOUR LIFE AND ALLOWING THE GOVERNMENT INVOLVEMENT TO PUT INTO LAW ACROSS THE LAND GIVING SOMEONE ELSE POWER OVER YOU IN YOUR MOST CRITICAL TIME WHEN YOU NEED TENDER CARE, NOURISHMENT, FAITH AND HOPE. THE LIVING WILL IS A STEPPING STONE TO EUTHANASIA. WITH DEEPEST CONCERN I AM VERY TRULY YOURS
ANNETTE M MCKINNEY 418 CENTRAL AVE SUMMERVILLE SC 29483

2235 EST

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CITIZENS UNITED RESISTING EUTHANASIA (C
R. 1, Box 3, Shepherdstown, WV 25443

James Hollingsworth
512 Carpenter Rd.
Charleston, SC 2941

Testimony to
South Carolina Joint Legislative Committee on Aging

Across America, we celebrate the bicentennial of our Constitution, while in our courts, its protections of life and liberty are routinely ignored.

Did the Consitution stop Clarence Herbert, 55, from dying a "life boat death, a prison camp death, the classic death of dehydration and pneumonia" (to quote the Los Angeles County District Attorney's office)? Mr. Herbert was fatally deprived of food and water at Kaiser Permanente Hospital in Harbor City, California. He took six days to die. If this isn't murder, and murder most foul, what is?

There are all too many of these "classic" deaths on hospital wards, in nursing homes, and hospices. And we can only speak of those that manage to penetrate the white-coated curtain of silence which surrounds the increasingly pervasive practice of medical murder.

Where were the self-styled champions of the Consitution when Paul Brophy, 49, was starved to death?

Indeed, where were its Constitutionally-designated guardians?

The Supreme Judicial Court of Massachusetts took a stand--a stand in favor of the death of Paul Brophy, a stand in favor of the death of American civilization. As Mr. Brophy's, attorney observed, "It (was) a dark day for (our) citizens, especially those at the edges of life, such as the aged, the infirm, the handicapped, the profoundly retarded, and even the unborn."

Where was the Supreme Court of the United States when Nancy Ellen Jobes, 32, was murderously denied food and water in New Jersey?

They voted 7 to 0, not even to grant her stay of execution. This is the Court that some will try to tell you is in danger of becoming "pro-life" with the Bork nomination.

Try telling that to the 10,000 Americans living in coma, marked for extermination by the euthanasia Axis. To the countless other targets--t mentally deficient, the mentally ill, the simply confused. For the coming euthanasia holocuast will dwarf the abortion body count in short order.

Americans have a fascination with history, but history as nostalgia, not history as a teacher. But the lessons of history, even when ignored, are no less an omen.

The day Mrs. Jobes died, Citizens United Resisting Euthanasia (CURE), called for an American Nuremberg Tribunal to try the planners and perpetrators of the euthanasia holocaust.

As Leo Alexander, a prosecuting attorney at the original Nuremberg Trials, observed, about the contempt for life of their predecessors:

"Whatever proportions these crimes finally assumed, it became evident to all that had investigated them that they ahd started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived."

Representatives of the State of South Carolina, members of the South Carolina Legislative Committee on Aging, I pray you will no find yourselves in the dock. And that you will not be found guilty of the crime against humanity, which euthanasia, in any of its guises constitutes, before the bar of God or man. Thank you.

James Hollingsworth

James Hollingsworth
State Director
CURE
October 7, 1987

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